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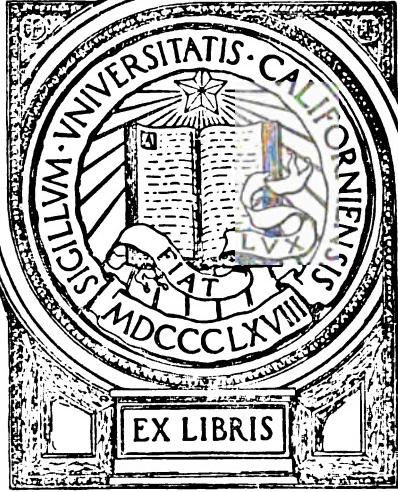
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# THE HAHNEMANNIAN MONTHLY.

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JANUARY, 1896.

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## THE HISTORY OF SURGERY.\*

BY WILLIAM B. VAN LENNEP, A.M., M.D.,  
Professor of Surgery.

It has fallen to my lot, gentlemen, to act in the capacity of starter, so to speak, in the race which begins to-night and will end next May. In the four years' course just inaugurated you may be appropriately divided into two general classes—those who will, in the main, lay and complete the foundation of a medical education, and those who will build and put the finishing touches on the superstructure. The decorations, appointments and furniture will depend upon your subsequent industry and success. You will follow the same plan in the study of surgery, beginning with the fundamental principles that underlie it, after which you will learn its more practical aspects. A knowledge of the development of the subject through the past centuries, up to the time at which you become acquainted with it, should be interesting and instructive to both of these classes. I therefore propose to inaugurate the course that has recently been placed under my direction by a brief his-

\* Introductory Lecture to the Forty-eighth Session of the Hahnemann Medical College of Philadelphia, September 30, 1895.

torical sketch of surgery, and trust that this may be a supplement to the admirable history of anatomy given us a few years since by our respected and beloved dean.

In considering the progress of surgery among the ancients, we find it making advances with the different culture epochs of history among the Egyptians and Jews, the Indians, the Greeks and the Romans. While it is true that human skulls have been found which prove that trephining was practised in pre-historic times, yet the earliest records of an official system of medicine come from Egypt. This is contained in the Papyrus Ebers, supposed to have been written 1552 B.C., more than a century before the exodus of the Jews, but they carry us back fully 3000 years more. They show that diseases of the eye, so prevalent yet in the valley of the Nile, were even then well understood and successfully treated. Blood-letting, amputations and Eunuch castration were practised, the instruments used being, principally, cauteries and forceps of all kinds. Judging from the badly united fractures met with in mummies, we can infer that the subject was poorly understood; but, on the other hand, dental science must have been well developed, many fine specimens of artificial teeth being met with.

Medicine was practiced principally by the priests, who were the inspired servants of the Deity, and owed their influence to the fact that most diseases were looked upon as punishments inflicted by divine power. Hence, sacrifices, charms, incantations and miracles played a prominent part. Aside from them, there were other physicians, educated in the religious schools, or by the state, who were either servants or bound to treat the poor without remuneration. Dispensary practice evidently had no charms for the priests. Thus, in Genesis, it is said that Joseph commanded his servants, the physicians, or dressers of wounds, to embalm his father, and the physicians embalmed Israel. The esteem in which they were held is shown by the sarcastic statement that King Asa "in his disease sought not to the Lord, but to the physicians. And Asa slept with his fathers."

The Jews have left but little, aside from an occasional Bible allusion, to tell us of the state of the art of healing in their day. In the Talmud we have some specimens of their surgery prior to 200 A.D. The rabbis, aside from their ritualistic operations, sutured wounds, freshened the edges of old ones, oper-

ated for imperforate anus, and used the uterine sound and substances to deaden pain during operations. They were acquainted with prosthetic appliances and artificial teeth; in short, what they had brought with them from Egypt, on which was grafted some of the learning derived from the Greeks.

The medical records of India are a mixture of the ideas of antiquity in that land, mingled with more recent importations, the date of their composition being variously estimated at from 1000 B.C. to 700 A.D. Susruta is considered the father of Indian surgery, and his writings are a commentary on the ancient Ayur Veda or the "Book of Life." He is said to have gone with some friends to the god Dhanvantari, who taught them in the conversational or subclinic style. They must have been a credulous class, for the venerable deity began by telling them how Yajna's decapitated head was united to his body by the twin Asvins.

There are three periods in Indian history, and the same is true of their medical science. The first period is represented by the hymns, incantations and sacrifices found in the Ayur Veda, disease being looked upon as the work of wicked spirits, health that of the good. The second, that of the Brahmins and Buddhism, is the bright one for Indian medicine. Its influence was felt in the third period—that following the conquest by the Arabs and the introduction of Mohammedanism. The priests here also were the physicians, although others are mentioned, and, owing to the prevailing castes, there were two classes of the latter—the nobler, who practised surgery in general, and the servants, who confined themselves to minor operations, boring the ears, shaving, scarifying, bleeding, etc. The Indian physicians wrote industriously, translating their works into other Asiatic languages, and established hospitals and drug shops. Anatomy was not known. Military surgery appears to have received considerable attention, as well as the hygiene and surroundings of the wounded, even iron bedsteads being mentioned. Anæsthetic oils and healing plants were applied to wounds, and haemorrhage was arrested by the cautery. Of the one hundred and twenty-seven instruments described, most of them are cautery irons, forceps, probes and tubes. Fractures were recognized by crepitus, reduced by extension and counter-extension, while the bamboo splints described are in use to this day.

Wounds of the head, face and trachea were sutured, and enlarged lymphatic glands and tumors excised. To prevent recurrences in malignant growths, the wound was filled with arsenical paste. Stone was removed by "cutting on the gripe" and by the suprapubic route, and even cataracts were extracted. More remarkable still is the fact that laparotomy was done for bowel obstruction and intestinal suture practised. Probably what has immortalized Indian surgery more than anything else, is the well-known plastic procedure in use to this day, the origin of which was in the common punishment of cutting off the nose.

The most important chapter in the history of surgery among the ancients is that of the Greek hero period. Homer shows considerable practical knowledge of wounds, and classifies them according to their surface location and their fatality. *Æsculapius*, afterwards deified, and his two sons, are mentioned as surgeons in high repute at the time of the siege of Troy, about 1000 B.C. During the ensuing four or five centuries, a great many temples of *Æsculapius* sprang up over Greece and the islands of the Archipelago, those of Cos and Cuidos gradually becoming the most celebrated. About these temples there collected an association or brotherhood who claimed descent from *Æsculapius*, and were known as *Æsclepiadæ*. They were entirely distinct from the miracle-working priests of *Æsculapius*, who inhabited the neighboring temples. Their schools were simply the residences of medical families, each one distinguished for some particular method of treatment. Records were probably kept and handed down from generation to generation. Even at the present time there are Epirus families in which a specialty passes from father to son, some being bone-setters, others stone-cutters, and others again herniotomists and oculists. As the different schools or families became better known, they formed brotherhoods or guilds, and made conditions of membership and directions for conduct in the shape of oaths, the Hippocratic oath being one of these; and the section that forbids cutting for stone was probably inserted because the operation, as then performed, usually unsexed the patient. Besides these medical families and the priests, there were the military surgeons, such a service, in fact, being considered essential to a complete medical education. The directors of the

gymnasia, too, acquired considerable repute in the treatment of the injuries most frequently befalling their pupils, *i.e.*, fractures and dislocations. The doctrines of the school of Cos are best known through the writings of Hippocrates, or, more correctly, the Hippocratic collection, which consists of his own works, combined with those of his pupils and what they gathered together. Amputations and the removal of major tumors did not receive much attention on account of their poor knowledge of anatomy and their dread of haemorrhage. Gangrenous limbs were allowed to drop off, or removed by cutting through the dead tissue, where there would be no bleeding. Fractures and dislocations, very common among the active and athletic Greeks, were well understood and successfully treated, the frequently mentioned dislocations at the knee being probably met with among their wrestlers. The treatment of cranial fractures corresponds in many respects with that of to-day; but, strange to say, while exploration of the skull was recommended in scalp wounds, together with trephining for bone contusions and fissures, depressed fractures were left alone.

Hippocrates was born at Cos about 460 B.C., and came of a family of physicians. He studied in the home school and travelled extensively, visiting all the centres of learning of the day. His writings have probably made the most lasting impression in medical history, his especial characteristics being his honesty and truthfulness.

Following Hippocrates, and almost his contemporary, was Aristotle, born 384 B.C., who gave a new impetus to surgery by inaugurating the study of anatomy. Through his influence, and that of his pupils, the famous school of Alexandria was founded, and the headquarters of medicine passed to Egypt. For a short time dissections of human bodies were permitted, and, as a result, several eminent anatomists were developed. What we know of their work, and that of the surgeons of the Alexandrian school, has come down to us in the writings of Celsus. The surgeons who enjoyed the greatest repute were Philoxenos, Sostratos, the two Apollonios, and Ammonios, named Lithotomos.

Celsus has been termed, with Hippocrates and Galen, one of the fathers of medicine. He lived in Rome at the beginning of the Christian era, and was an author, not a physician. His

work was an encyclopaedia of the arts and sciences of his time, and was intended for the use of educated laymen, not for professional men. The eight sections on medicine, copied after Hippocrates and the Alexandrians, were especially valuable to the wealthy land- and slave-owners as a system of domestic medicine and surgery; in fact, Celsus was not quoted by medical writers for over a thousand years, his contemporaries looking down upon the work of an amateur. His *de re medica*, however, was one of the first works printed, and has since been extensively studied and quoted. The lesson to be learned from the work of Celsus, the medical Cicero, is an instructive one to all of you who are entering the field of medicine. If you seek fame, or if you seek to learn, write. Nothing will teach you more than the attempt to impart your knowledge; nothing will make you better masters of your subject than the attempt to submit your ideas to writing. The very continent upon which you live is not named after the genius who discovered its shores, but after the man who "wrote it up." And whenever you write, be sure to write—*your best*.

Next to Celsus, Galen is the best-known author of his time, over 500 treatises on medicine being attributed to him. Distance here certainly must lend some enchantment! Of Greek extraction, he was born in the year 131 of our era, was educated in Corinth, Smyrna and Alexandria, and practised in Rome. His ideas are practically those of Hippocrates and of the Alexandrian school, and are of medical rather than of surgical value.

There were several classes of physicians in Rome—those who were free, and practised and taught in their own establishments or at the bedside. These were at first the Greeks, who always held a high place in public esteem, and then the Jews, free Romans, particularly of the upper classes, rarely following medicine. Then came the slaves, captured principally in the Roman conquests in the Orient, who were used as household doctors or taken as attendants in war. Slaves were also educated in the above-mentioned schools. Besides these, there were the surgeons for the theatres, for the circus and for the gladiators, as well as those holding army and navy appointments.

Probably the brightest period for surgery in Rome was be-

tween the second and fourth centuries of our era. Such men as Archigenes, Heliodorus, Leonidas and Antyllus were well acquainted with anatomy and practised operations which have since been published as marvellous. With the decline of the Roman empire, however, culture and science came to a standstill. In Constantinople the encyclopædia was revived, and compilations of medicine and surgery were made by Oribasius in the fourth, by *Ætius* in the sixth, and, above all, by Paul of *Ægina* in the seventh century.

Having run over the writers and surgeons of the Greek, Alexandrian, Roman and Byzantine eras, let us for a moment consider their contributions to surgery. Celsus and Galen refer to the ligature as well known, but its use seems to have been confined to ligation in continuity, although it was occasionally applied to both ends of a divided vessel. In haemorrhage from wounds, compression, cold, vinegar and other styptics were recommended, caustics being reserved for extreme cases, on account of the inflammation produced. Heliodorus used the tenaculum, and made torsion, and among the instruments found in the ruins of Pompeii and Herculaneum are haemostatic forceps. Strange to say, neither the ligature nor torsion appears to have been applied to amputations. Leonidas and Heliodorus employed the saw and linen retractor, cut through healthy tissues, and even formed flaps, but controlled the bleeding by hot irons. Archigenes at times applied a preliminary ligature to the main vessels or even an elastic band around the entire limb—the so-called Esmarch method of to-day. Paul of *Ægina* first mentions the difference between arterial and venous haemorrhage, and the name of Antyllus will always be associated with his method of treatment for aneurysm—that of proximal and distal ligature, close to the sac, with excision of the latter. Trephining was frequently practised, depressed bone being removed and fissures recognized by pouring on ink. In fractures of the spine an attempt was made to extract the compressing bone by incision. Tracheotomy also was accurately described. Resections for necrosis were often done by Antyllus and Heliodorus, while tumors were removed by the former, haemorrhage being prevented by the double preliminary ligature. Carcinomata were let severely alone unless seen early, before the undoubted signs of

malignancy became manifest, when excision gave the only hope. The different metastases were well understood. Lithotomy being forbidden by the Hippocratic oath, Celsus was the first to describe "cutting on the gripe," an operation now known as the Celsian. Ammonios added litho-clasis, or the breaking up of large calculi before extraction, while the Byzantine writers make mention of lithotripsy. Genito-urinary diseases appear to have been well understood by Heliodorus, who did internal urethrotomy and employed paper bougies and metallic sounds.

With the capture of Alexandria by the Arabs, about 640 A.D., the dark or middle ages began. Owing to their belief in fatalism and their ignorance of anatomy, it can be readily understood that surgery made but little progress under Mohammedan rule. The prince of Arabian physicians was Avicenna (1000 A.D.), who for five centuries rivalled Galen as an authority. His writings are those of the ancients, mingled with Oriental philosophy to such an extent as to make their chief virtue the difficulty in understanding them. Another celebrated writer of the eleventh century was Albucasis, a native of Spain, who also brought out an encyclopædia, based largely upon the one by Paul of Ægina. When haemorrhage occurs in the excision of tumors, he says it should be arrested by vitriol powder or some other styptic, and the operation postponed until the sloughs separate. For amputations and the radical cure of reducible hernia he advises the actual cautery, not the knife.

Throughout Europe medical science was that of barbarous nations. All progress was made impossible when the Benedictine monks became the practitioners, their knowledge of medicine being confined to a few simple formularies and receipt books, while relics, miracles, and prayers were their main reliance. The Jewish physicians were the writers and the students of the teachings of the ancients, but to employ them required the ability to protect them from priests and mobs. Popes, prelates and kings, however, did not hesitate to call upon them. That they were a fad is shown by the fact that Francis I. lost all confidence in his Jewish physician when he learned that he had turned Christian. By the advice of another, unregenerate Israelite, however, "he drank asses' milk and got well." Surgery was relegated to barbers, bathers, and seventh sons,

who, with butchers and shepherds, were the most despised of men. The peripatetic and hereditary specialist was very common. Even those who could afford a surgical education found few clinical opportunities in the lecture-rooms of the universities, but the crusades in the eleventh, twelfth, and thirteenth centuries furnished them a rich field for practical experience. The hardships of travel and the dangers of war did not appeal to the sedentary and literary physicians who were mostly priests, and in consequence there appeared a class of active and skillful surgeons and operators holding a far better social position than the barbers and itinerants.

As Italy gradually awakened from the ruins of the Roman Empire, the first faint ray of the revival of letters appeared in the University of Salernum, which owed its reputation to the writings of one Constantine, a Carthaginian of the eleventh century, who had traveled extensively in the East. The teachings of the institution were based consequently upon the works of the ancients, but gradually became more and more Arabic, until it was ultimately superseded by those of Naples, Bologna, Paris, and Montpellier.

The principal surgeons of the Salernitan school were Roger and Roland, in the twelfth and thirteenth centuries, and, in the fourteenth, the much written of and romantic Four Masters. The latter, four brothers, are said by some to have lived in Salernum, by others in Paris, where they treated the sick poor in a surgical dispensary.

The history of European surgery really begins with the first original writer, William of Salicet, of Bologna, in the second half of the thirteenth century. While apparently familiar with the works of the ancients and the Arabs, he mostly gave his own observations and those of his contemporaries, with some deductions therefrom. He strove to revive operative surgery and to restrict the use of the cautery, urged the union of medicine and surgery, and described venereal diseases. Early in the fourteenth century an important change was brought about by the banishment from Milan, for political reasons, of Lanfranc, a pupil of Salicet. He introduced Italian ideas into France, whose schools in turn outstripped those of Italy, Paris becoming particularly celebrated for surgery, and Montpellier for medicine, while Bologna still remained the anatomical

centre. Lanfranc and his contemporary, Henri de Mondeville, both taught surgery in Paris, and brought the college of St. Côme to a short-lived pinnacle of prosperity. This institution, founded by Jean Pitard, is of great historical interest on account of its connection with the controversy between the physicians and surgeons. Surgery in France was distinct from medicine, and, being a trade, was looked down upon by the educated physicians; in Italy they were surgeons as well, the more proficient being the teachers of anatomy. The physicians too, at an early date, were mostly clericals, who despised manual labor, and considered the soiling of their hands beneath the dignity of their profession. Besides, these medical priests had their heads frequently shaved and were bled at stated intervals. Hence, as a matter of convenience, the barbers performed both these duties, and also did their manual and bloody work, their surgery. Their traditions were adhered to after the universities passed into the hands of the laymen. The fact has been alluded to that aside from these ordinary barbers, employed and directed by the physicians, there were others who performed operations and held a higher position. They were known as the "clerk barbers," and the Guild of Barbers soon became divided into two classes, the "lay barbers" or *surgeons of the short robe*, and those of *the long robe* or the clerk barbers. The latter formed the College or Brotherhood of St. Côme, and sought to monopolize surgery by examining and licensing boards of their own choosing, like the philanthropic (?) allopath of to-day; they also strove to raise their college from the position of a trade guild to that of a professional organization by forming a separate faculty in the university. And here the trouble began. The physicians fearing that they would lose control of all branches of the art, took sides with the surgeons of the "short robe," who also saw their *flesh pots* passing into the hands of their confrères of the "long robe." They first attempted to instruct these lay barbers in anatomy, but Latin, the only dignified and proper language in which to teach, was not understood by the ignorant unfortunates; hence a dog-Latin, that is French words with Latin endings, was invented, and surgery and anatomy taught them. The brothers of St. Côme finally had to yield and be instructed and governed by the faculty of medicine. It was Ambroise Paré's reputation and influence that, later on, gave standing and respectability to the guild.

Guy de Chauliac was the great French surgical author of the fourteenth century, and his teachings, although showing but little originality, were the chief authority for fully two hundred years. His summary of the five methods of wound treatment of his day is striking to say the least: 1. The sect of Roger, Roland and the Four Masters poulticed them. 2. That of Bruno and Theodoric anointed them with wine. 3. The school of Salicet and Lanfranc dressed them with ointments and plasters. 4. Military men and Germans treated them with conjurations, potions, oil, wool and cabbage leaves. 5. Finally, women and many other fools said: "The Lord was pleased to give it me; the Lord will cure me when he sees fit; blessed be the name of the Lord." The old Frenchman was evidently not as gallant as his modern fellow-countrymen.

As surgery moved to France early in the fourteenth century, so again, in the beginning of the fifteenth, we find it returning to Italy. This period is noted for the introduction of gunpowder into warfare (1338) and for the invention of printing (1460). Of necessity, they had an influence on wound treatment and on the dissemination of surgical literature. The only writer of any consequence during this century, and that at its close, over one hundred years after Guy de Chauliac, was John de Vigo (of Rome), whose work ran through many editions and was extensively translated. He first described the "new disease" syphilis, and the new injury gunshot wounds, for which he advised the hot iron and boiling oil. The art of printing soon gave birth to the composite systems of surgery so popular to-day, the first two being known as the Venetian and the Geneva (or Gesner's) collections, in which the most important works were edited together and illustrated by wood-cuts. We can get an idea of the slow spread of knowledge in these days, however, from the fact that the so-called Marian operation was kept a family secret nearly two hundred years after the publication of the method by two well-known authors; and yet this is not to be wondered at when we think of the status of surgery and when we read a remark by Michael Angelo Blondus, which shows the narrow university spirit of the time. He says: "It is more honorable to err with Galen and Avicenna than to acquire glory with others," and "it is better to die by a regular physician than to live by a quack."

Of far greater importance, surgically, were the *cutters* or *incisors* of Sicily and Southern Italy. They belonged to families in whom different operative measures were handed down from father to son—lithotomy, herniotomy, urethrotomy, cataract extraction, plastic surgery, etc., and were undoubtedly of Greek extraction, originating probably in Epirus. Many of them were itinerants, but, after acquiring fame, they sometimes settled in the great cities, and even imparted their secrets to others. The best known were the Norsini, a family named from their town in Calabria, and it is supposed that one of them taught John de Romanos how to cut for stone on a staff. The pupil of the latter, Marianus Sanctus, published (in 1535) an account of the operation since known as the Marian, or the “method with the great apparatus,” as distinguished from that with the “little apparatus” of Celsus. It was well named, for the numerous dilators and divulsors used after the median perineal section would fill a large table, if not a room. A French family by the name of Colot practised the operation very extensively in all parts of Europe for three generations, over a period of more than one hundred and fifty years. Others of these Italian incisors acquired fame from their radical operations for hernia, using, it would appear, a combination of the cautery of the Arabs and the incision of the ancients. The Sicilian family of Branca were noted for their work in plastic surgery, the father using the Indian method, the son taking the flap from the skin of the arm. His method of rhinoplasty, since known as the Italian in contradistinction to the Indian, was described at the end of the next century by Tagliacozzi, after whom it has also been named the Tagliacotian. A curious field for plastic surgery in those days was the forming of artificial double monsters, two children being grafted together by the back, nates or arms. It would indeed be strange if, in the mad museum competition of to-day, this form of Italian plastic work did not have its *renaissance*!

With the close of the fifteenth century and the discovery of the New World, we leave the Middle Ages and pass into modern history. In looking over the surgical work of the era just reviewed, and comparing it with that of the Greeks, Alexandrians, Romans and Byzantines, we find that the superstition and intolerance bred of Mohammedanism and priest rule caused

it to go backward instead of forward. Operative surgery was relegated to the uneducated and despised specialist and barber, to some of whom all the more credit is due for acquiring an admirable technique and a remarkable experience which they bequeathed to more enlightened generations.

The treatment of wounds retrograded, too, suppuration being thought healthy, primary union wrong. The tenacity of error is shown in the so-called "laudable pus" of recent times. They were accordingly dressed with plasters, ointments and poultices. Even the richest of wines were offered the prolific micro-organisms, their diet being varied by cabbage, salad, aromatics, spices, and, occasionally, by substances of less agreeable odor and taste. The ligature was described after the ancients, but was rarely used except for ligation in continuity, catgut being mentioned as "the cord used in musical instruments." In its place the hot iron, of all shapes and sizes, even of gold and silver, medicated caustics, since known as "the Arabian cautery," and the filthier styptics, ensured sloughing and the much-desired suppuration. With a few notable exceptions, such was the "regular" practice of the Middle Ages, and we turn with pleasure to the Luther of Surgery, Ambroise Paré, by far the brightest light of a century which, next to our own, is perhaps the most important in surgery. The advances made were due to the universal revival of letters and the more general study of practical anatomy. The standing of the barber surgeons was much improved, and they could even aspire to be the attendants of the king. Their practice was enormously increased, too, by the spread of the new disease; they had treated skin troubles and the poor, but as syphilis was no respecter of classes, they were soon employed by the rich. The constant wars of the century, furthermore, gave them a rich field for experience, but of still greater value was the universal use of firearms. Gunshot wounds were entirely different from those hitherto met with, and hence the teachings of the ancient masters had to be cast aside. Thrown on their own resources, or, better perhaps, freed from the bondage of tradition, original thought and experience held sway for the first time since Hippocrates.

Paré was born in 1517, and was first apprenticed to a provincial barber and then to a barber surgeon in Paris. He at-

tended the lectures given to the barber surgeons by the faculty of medicine, and had a three years' residence as dresser in the great hospital, Hôtel Dieu. His opportunities for dissections, post-mortem examinations and the study of disease were thus very extensive. Beginning practice as an army surgeon, his first service was to change the recognized treatment of gunshot wounds. These were looked upon as poisoned, and were cauterized with boiling oil. The supply failing in one battle, he was surprised to find, after a sleepless and anxious night, that those who had not been burnt were comfortable and made quick recoveries. He thus was led to treat them with simple dressings, looking upon them as contused rather than as poisoned wounds. What has immortalized Paré, however, is his application of the ligature to amputations. Having used it as described by the ancients, it occurred to him to apply it to amputations, and he soon successfully carried out his plan, although, as he says, the cauteries were at hand in case the ligatures failed. No description of this great revolution can compare with the impressive and familiar illustration by Matout of Paré at work on the battle-field. The seething pots of oil, the hot irons and the anguish of their victims tell a sickening tale, while the faces of the "regulars" show too well the bitter opposition he received. Such was the conservatism of tradition that the cautery was still in use as late as the eighteenth century. The ligature also had its drawbacks in the imperfect instruments to aid in its application, and in the fact that secondary haemorrhage was common on account of wound suppuration. Paré was perhaps the only Protestant in Paris who escaped the massacre of St. Bartholomew, and this he owed to the esteem and respect of the king. When asked by Catharine de Medici how he expected to be saved, he rebuked the religious belief of the time by saying he was sure God understood a French prayer as well as one in Latin. This strange reflection on the omniscience of God is found to this day among oriental Jews who, carrying on a heated discussion in Hebrew, will, when they indulge in abuse and profanity, change to Turkish, Arabic, Greek or Armenian, which are not understood in heaven!

Paré, of course, had many pupils and followers, and among those best known for their writings and work are Guillemeau, de Marque, Pineau, Pigray and Habicot. His most prominent

contemporary, and in many respects his equal, was the cutter, Pierre Franco. He is best known for his contributions to lithotomy, having practised epicystotomy, known then as the *apparatus altus*, and the lateral cut, or the *apparatus lateralis*. He did much, too, to improve both the mechanical as well as the operative treatment of hernia. Hitherto, castration had been at least one of the drawbacks of the radical cure, and so common had this become in Paris that the authorities were obliged to forbid the operation, the frequency of which was also lessened by improved trusses. Franco was one of the first to recognize and operate strangulated hernia, the ancients and their imitators having included the resulting symptoms under the general head of "ileus," which was never touched.

Pfolzpeundt was the first German writer, and he had evidently learned Branca's method of rhinoplasty, and mentions a narcotic mixture of mandrake and henbane which was dried in a sponge and wet previous to inhalation. Strassburg, from its proximity to France and Italy, was more advanced, and produced two military surgeons of repute, Brunschwig and Gersdorff. They wrote largely of gunshot wounds, which they probed, extracted the bullet, and drained. Gersdorff used flaps for amputations, bringing them together over a styptic and holding them in place with a pad and a wet ox-bladder. The first step of the operation was for the patient to "resign himself to God, to confess his sins, to remember the sufferings of our Lord with thanks, and *the surgeon the same*." The styptic used was complex enough to frighten any haemorrhage: unslackened lime, 2 ounces; vitriol and alum, each 1 ounce; aloes, gall-nuts and colophony, each  $\frac{1}{2}$  ounce; of the residue from a retort in which aqua fortis had been made,  $2\frac{1}{2}$  ounces; and the white hair of the belly of a deer chopped up; all to be mixed together and with the white of eggs before using. Paracelsus, short for Phillipus Aureolus Theophrates Bombastes de Hohenheim (1493–1541), was an original thinker and a decided iconoclast. He taught that it was not the surgeon who cured wounds, but the juices of the body, and inveighed against the practice of making wounds suppurate. These ideas are not so far from those of the wound healing and the phagocytosis of to-day. He also made a preparation from the juices of portions of the body not unlike the recent craze for animal extracts

started by Brown-Séquard. His follower, Wurtz, was a caustic writer, who also aimed at simplifying wound treatment. He condemns poultices and describes pyæmia, a most natural combination, and it is a pity indeed that his advice is not more closely followed even at this enlightened day. He claimed that the blood in a wound was a right fresh glue, which hastened healing, and deprecated the use of boiling oil, styptics and hot irons.

During the seventeenth century surgical progress is thrown into the shade by the wonderful advances in physics and physiology. Thus in the former we have the familiar names of Bacon, Descartes, Newton, Boyle, Pascal and Galileo; in the latter, Sydenham the English Hippocrates, Malpighi and Leeuwenhoek the histologists, and above all, Harvey, who discovered the circulation.

The teachings of Paré showed their influence in Italy, but in France surgery was at a standstill until near the end of the century. Thus we see the surgical pendulum again swinging forward and back between these two countries. In Italy the surgeon was more than ever the anatomist. Aquapendente, of Padua, the pupil of Fallopius and the teacher of Harvey, was more eminent in anatomy than in surgery in which he was at most an admirable compiler of the ancients. He described tracheotomy and the use of the animal trachea for the end-to-end union of divided intestine. Magate, of Ferara, simplified the treatment of gunshot wounds on the principle that they were contusions or fistulae, and advised less frequent dressing, while Severinus, of Naples, improved that of abscesses in a classical treatise. Spigelius, of anatomical fame, and Marchetti trephined for severe headache, insanity and chronic diseases of the eye. The former trephined a patient seven times, and the latter did the same operation successfully for a dagger wound of the brain. Van Derwill (1620-1687), a Dutch surgeon, is said to have trephined the Duke of Nassau twenty-seven times and after the last operation his highness lived for many years. Marchetti's son, Dominique, probably performed the first nephrotomy without local tumefaction as a guide.

In France, lateral lithotomy was popularized by the travelling cutter, Beaulieu, commonly known as Frère Jacque, an ignorant

monk, while Ciucci, after having the operation done on himself, practised lithotripsy with an instrument much like the more recent one of Civiale. To de Blegny probably belongs the credit of founding the first medical journal. Morel devised the "Spanish windlass" (1674), which soon led to the screw tourniquet of Petit (1718), and to Saviard's treatment of aneurysm by digital compression (1702).

Of Germany there is little to be said during this period. Hildanus shares with Heister, according to some, the title of the Father of German surgery, but although a voluminous writer he contributed little that was original. With Purmann and Muralt he used flaps in amputating, and advised early operation, and incision through the sound instead of the dead tissue in gangrene. The name of Scultetus comes down to us in his well-known bandage.

At about this time there arose a bitter controversy concerning the "sympathetic or magnetic" wound treatment, an outcome it is claimed of the teachings of Paracelsus. The instrument inflicting the injury, or a piece of cloth, was wet with the blood, anointed and put away carefully, nothing but lint being applied to the wound. The priests claimed that it was a wile of the devil, but probably the wounds were the better for the simple dressing.

I may be pardoned if I dwell for a moment upon the surgery of the Netherlands, for which the seventeenth century was a notable epoch, Yperman (1351) being about the only known writer previous to this time. Amsterdam and Leyden, by the middle of the century, became the centres of anatomical, surgical and obstetric teaching for the whole of Europe. Palfyn invented the obstetric forceps; Barbette first described femoral hernia, laparotomy for bowel obstruction, and experimentally extirpated the spleen; Van Roonhuysen was a skillful plastic surgeon, Verduyn an independent originator of amputation by flaps, Van Horne a distinguished teacher of anatomy as well as of surgery, while Tulp, Solingen and Van Meekren all contributed to render famous the land below the sea.

England too, deserves mention. Here we also find the guild of surgeons which was soon united with that of the barbers to form the Company of Barber Surgeons. They were taught for a long time by physicians, but we do not read of the bitter con-

troversies that went on in France. To this day surgeons are distinguished by the term Mister from the title Master Barber Surgeon. One of the earliest English surgeons we have any account of is John of Anderne (1308) who gives a graphic account of rectal cancer, of which he says, "As an owle hideth herself in the darke places, so this grieve lurketh within at the beginning, etc." Still more striking, perhaps, is the anaesthetic mixture and the rules for its use found in an old English book of about the same date. With equal parts of the juice of orpine, eringo, poppy, mandrake, ground ivy, hemlock and lettuce, clean earth was mixed and a potion prepared, which when poured into the patient's nostrils made him sleep without fail. To awaken him, a sponge pounded in vinegar was held to his nose; to make him "sleep for four days," a pennyweight of wax from a dog's ear and the same quantity of pitch were administered, and to arouse him from this slumber an onion compounded with vinegar was poured into his mouth.

King James III. was said to be "ane singular gude chirurgeon," and in his treasury accounts (1511) is the entry "Item to one fallow because the king pullit his tooth." Bavaria to-day has an eye-surgeon prince whose numerous cataract extractions probably have netted him less than this tooth. In the sixteenth and seventeenth centuries we meet with the names of Gale, Clowes, Lowe, Yonge, Lowdham, Woodall, and others. Clowes first punctured the intestine in hernia to reduce the tumor, a procedure not infrequently practised now in the distension of obstruction, while Arris and Gale originated the lectureships now so common in Great Britain. The leading English surgeon of the century was Wiseman, who has been termed the English Paré. He wrote very extensively, and although he did not employ the ligature, he included the cut artery in one of the stitches, as is frequently done to-day.

At the beginning of the eighteenth century Holland still held the position in medical teaching already referred to. Among the more prominent Dutch surgeons of the time were Rau, a celebrated lithotomist; Schlichting, the first to do neurotomy for facial neuralgia, and Monnikhof, herniotomist to the city of Amsterdam, who published the statistics of a thousand cases, the earliest collection of the kind.

Paris, however, soon became the centre for surgical study.

Of the greatest importance was the establishment of the Academy of Surgery, the successor of the college of St. Côme, with its practical school of surgery and surgical anatomy. It was founded in 1731 by Mareschal, and among its prominent members were Louis, who pronounced the eulogies on the deceased members, which are of great historical and biographical interest; Le Cat, the prize essayist of his day; Le Dran, who first disarticulated the arm at the shoulder, and others. Besides these there were a number of writers and surgeons of prominence, and the names of many of them have come down to us in connection with different operations, instruments, etc. Thus Chopart has given his name to the well-known amputation of the foot, Bellocq to the canula for epistaxis, Brasdor to complete distal, and Anel to close proximal ligation for aneurysm. Littré's name is associated with the hernia in which only a part of the bowel is constricted, while Arnaud described protrusions through the obturator foramen. Mery first tapped the bladder above the pubes, Ronsil resected the cæcum and portions of the colon and ileum; the monk, Frère Côme, extensively used his lithotome caché, Sigault did the now popular symphyseotomy, and Andry wrote the first treatise on orthopædics. The most prominent man of the first half of the century was Petit (1674–1750) a fine anatomist and original surgeon. He invented the tourniquet named after him, demonstrated the occlusion of vessels by clot, and amputated by first dividing the skin and then the muscles, instead of by one circular stroke as heretofore. In the second half of the century Desault occupied a similar position. He was the first teacher of surgical anatomy in the modern sense of the word, but wrote nothing, his pupil, the famous anatomist and writer, Bichat, familiar to you from the fissure that bears his name, publishing his ideas. He tied the axillary artery, improved surgical technique and the treatment of fractures, a bandage still taught bearing his name.

It was not long before France was outstripped by England. The effect of Harvey's discovery was felt, and while in the former country the surgeons were most of them anatomists as well, in Great Britain physiology, and later pathology, were given a prominent place, a combination that has been wonderfully fruitful. The first step forward was the elimination of the barbers and the formation of surgical organizations of educated men. The pioneer of the century was Cheselden, best

known by his "lateral operation for stone," which soon became the fashion. He was an original thinker and clear teacher. His pupil, Sharp, devised the trephine as used to-day. The treatment of aneurysm received much attention; Bromfield originated compression of the subclavian on the first rib. He also perfected the ligature, drawing out the vessel with a tenaculum and isolating it, and described bilateral lithotomy. Warner tied the common carotid, Blizzard the superior thyroid and subclavian, and Abernethy the external iliac. The latter also performed neurectomy in the forearm, and found that the ends soon united again. The names of Park, of Liverpool, and White, of Manchester, are associated with operations on joints, the former resecting the knee and elbow, and the latter first excising the hip, while that of Hey, of Leeds (1733-1819), is familiar through his skull saw. Another name giver was Percival Pott (1713-1788), best known by his description of spinal caries (Pott's disease) and the fracture at the ankle, which he had an opportunity of studying on himself (Pott's fracture). In Edinburgh was Alexander Monroe, the first of three generations who occupied the chair of anatomy and surgery for one hundred and twenty-nine years, and Benjamin and John Bell, both able surgical writers. The name that has given the most lustre to English surgery in the eighteenth century is that of John Hunter. His brother William, ten years his senior, a cultivated scholar and polished gentleman was a teacher of anatomy and surgery. When twenty years old, John, an ignorant, uncouth, dissipated Scotch farmer lad, went up to London to assist his brother in the dissecting room. Having completed his surgical studies he entered into partnership with his brother, and devoted himself with an industry that is almost beyond comprehension, to human and comparative anatomy, experimental physiology and surgery, and to the foundation of the splendid museum that bears his name. As a public teacher he was not successful, but his private pupils, Jenner, Abernethy, Cooper, Physick, Hume, and others, became the leading men of the day, and did much to perpetuate and expand his methods and ideas. His best works are on *Blood, Inflammation, and Gunshot Wounds*, and on venereal diseases, while his main contribution to operative surgery is proximal ligation for aneurysm at a distance, where the vessel coats are healthy.

Germany was far behind her neighbors. Surgery was still

practised almost exclusively by ignorant barbers and wandering charlatans. Even the executioners were sought after because, a part of their business being to dislocate and break bones on the rack, they were supposed to have special skill in curing such lesions. Matters were as bad in the army, where the barber surgeons were obliged to shave the officers and perform menial duties. Surgery was so despised that it was impossible to get any but those of an inferior class and of but little education to serve. In consequence, surgical colleges were established in Berlin, Dresden and Vienna, for the purpose of educating medical officers for the army, and the military surgeons thus first acquired especial distinction, the best known being Schmucker, Bilguer and Theden. Of the writers and teachers, Heister, Haller, the von Siebolds, father and son, and Richter, deserve mention. Heister, already referred to as the father of German surgery, acquired world-wide reputation as a writer, being the first one to discard Latin and to use German in a surgical treatise. Richter published a work which is still the model for surgical text-books. Haller taught surgery theoretically but would never operate. We find an occasional example of this anomaly in the separation of the didactic and clinical chairs to-day.

There has been more surgical progress in the nineteenth century than during the entire history of the world. This has been largely due to the fact that the surgeon, no longer an ignorant cutter, became an educated physician as well. All the branches constituting medical science have been made to assist in this advance and nothing has done so more than the laboratory. To Hahnemann belongs, more than is generally thought, a large share of credit in this connection. Of his scientific medical law with which he emancipated the world from empiric medicine I need not speak. Your very presence here to-night, shows your belief in it. But experimentation on the healthy, or physiological medicine, as originated by him was the beginning of a new era. With more accurate methods of investigation the structure and functions of the body have come to be understood both in health and disease, while experiment has been made the basis of every step forward. Next to this comes anaesthesia, the greatest independent discovery of the world, and the possibilities that have been opened by it are beyond

expression. Then the revolution in wound treatment, based upon scientific principles, which has enabled the surgeon to attack diseased processes in every portion of the body. To these should be added the improvement in teaching by the establishment of laboratories, musea and libraries, by the unrestricted study of anatomy in its broad sense, and by the building of well-appointed hospitals in the great centres of population, with the invaluable corps of skilled nurses they educate. Finally, the numerous societies and the growth of medical journalism and literature, with rapid international communication, have disseminated surgical knowledge and made it cosmopolitan.

In the early part of the century most of the medical teaching in London was given in private schools. Probably one of the most famous was that in Windmill Street, established by William Hunter, and among the teachers were, besides the two Hunters, such men as Cruikshank, Mayo, Shaw, Brodie, Charles Bell, Cæsar Hawkins and others. It was not long before the teaching was transferred to schools connected with hospitals, among the earliest being those of Guy's, St. Thomas's and that of the London Hospital, founded by William Blizard. The surgeons began as demonstrators of anatomy, physiology, or pathology and assistant surgeons to the hospital; then became full surgeons and lecturers either in one of the above subjects or on surgery.

Among the prominent surgeons of London at this time were Astley Cooper, whose illustrations of fractures and dislocations are still copied in your text-books, and who first ligated the abdominal aorta; Hutchinson, the editor of the first surgical dictionary; and Wardrop, known by his modification of Brasdor's operation for aneurysm. Their successors were Benjamin Brodie, whose scientific attainments placed him for many years at the head of the profession in London, and Charles Bell, a younger brother of the two already mentioned, whose careful experimental work on the nervous system has made a lasting impression. In Edinburgh the chairs of surgery and anatomy were long kept combined by the Monroes. A private school of surgery was started in the College of Surgeons (1804), with John Thomson as the instructor. Anatomy was also taught in private schools. The famous Scotch surgeons of the time were Lizars, Liston, whose name is familiar to you by his "long

splint," while you know that of Syme through his amputation at the ankle; and Ferguson, who did much to advance conservatism in amputating. Returning to London, we meet with Guthrie, who disarticulated at the hip and made many improvements in military surgery; and, among provincial surgeons, Teale, known by his amputation of the leg. In Ireland, Colles published his law concerning hereditary syphilis, and described Colles' fracture, while Bellingham revived the treatment of aneurysm by digital compression. Among those of more recent date may be mentioned Coulson and Teevan, prominent genito-urinary surgeons; Cock, known by his operation for retention; Thomas Blizzard, who called attention to the acute duodenal ulcerations after burns; and Hilton, the author of *Rest and Pain*.

The greatest service of British surgeons is the introduction of systematic and scientific principles to govern the treatment of wounds, which has immortalized the name of Lister. Following the experiments of Pasteur, which showed that putrefaction is due to the action of micro-organisms, Lister sought to exclude these or to destroy their vitality if they had gained admission; and the development of the subject has been on these lines, exclusion leading to so-called asepsis, and their destruction, with the least possible injury to the tissues, constituting antiseptics. The latter has been aided by substances preventing their multiplication and the discovery of the phagocytic action of the white blood corpuscle. The results of Lister's researches and the development of bacteriology, of which Koch's culture media were the foundation, have completely revolutionized modern surgery.

It may be of interest to you to know that the first Lister dressing used in Philadelphia was applied by Dr. C. M. Thomas to a compound fracture of the leg in our clinic.

In France the medical faculties and societies were abolished at the close of the last century, and, as a result, there was a dearth of army medical officers so necessary in the wars of the republic. Surgical schools had to be established in consequence, and students were conscripted for them just as for military service. Medical universities soon followed, and the chairs for a long time were filled by competitive examination.

French surgical history in the nineteenth century may be

divided into four periods. In the first were Larrey, Napoleon's brilliant army surgeon and military teacher of surgery, and Boyer, the first to point out translucency in the diagnosis of hydrocele and to describe tendon crepitus. You will learn to use his dressing in fractures of the leg. In the second we find Dupuytren, familiar to you by his splint for Pott's fracture and by his enterotome. He was the most distinguished teacher of his time. Besides Dupuytren, there were Roux, who perfected staphylorrhaphy and repaired the perineum; Delpech, who practised tenotomy of the tendo Achillis by the subcutaneous method to exclude the air, and Lisfranc, well known from his amputations of the foot, wrist and shoulder, his resections of the head of the humerus and the lower jaw, and his excisions of the rectum and the neck of the uterus. Sourbebielle, a relative of Frère Côme, whose instruments he inherited, is said to have performed the supra-pubic operation over 1200 times. At about the same time appeared Civiale, Leroy D'Etoilles and Heurteloup, who practised lithotrity extensively and made the genito-urinary surgery of Paris famous. To the third period belong Velpeau, for thirty years one of the most prominent surgeons in Europe, who contributed extensively to operative surgery, regional anatomy and diseases of the breast, and whose bandage you will frequently use; Langier, the first to suture divided nerves and call attention to the serous discharge from the ear in certain skull fractures; Jobert, whose experiments on the intestines and whose suture have been recently revived with the most brilliant results. He also operated for vesico-vaginal fistula. To these must be added Amussat, who, although holding no hospital or faculty position, was a renowned private teacher, revived torsion for bleeding vessels and popularized lumbar colotomy; Vidal, the rival of Ricord in syphilography, Gensoul, the first to excise the upper jaw and parotid gland, Roux the originator of a disarticulation of the foot, and Pravaz, by whose name the hypodermic syringe is known throughout continental Europe. The fourth period really belongs to that in which we live, rather than to history, and we can only speak of those whose work is done. Malgaigne is looked upon as the greatest of surgical historians and critics, and inaugurated a new criterion for judging a surgical procedure, that of statistical tables and experiments. He did much

to improve the treatment of fractures, devised the patellar hooks that bear his name and suggested supra-thyroid laryngotracheotomy. Nélaton, his colleague, and a better surgeon, demonstrated the bullet in Garibaldi's ankle with his porcelain headed probe, while Chassaignac gave us the drainage tube and ecraseur. To Broca belongs the title of Father of Brain Surgery and his center of speech about the end of the fissure of Rolando will always proclaim the fact; he first trephined for brain abscess by using localizing symptoms for a guide. The name of Sébillot is associated with those of Nélaton, Malgaigne, Giraldès, Syme, Trélat, and others in the plastic operations on the lip, face and palate.

In Italy we find but few who have contributed to the art in this century. Scarpa was a celebrated anatomist and surgeon, as well as a fine artist. His name is perpetuated by "Scarpa's triangle." Of much later date is Rizzoli whose osteoclast has been extensively used.

Germany and Austria, though late in starting, have equalled or perhaps surpassed England and certainly France, in surgical study and advances. Following the military schools, where surgeons only were educated, came the universities, and here a distinction was made, five years being prescribed for medicine and higher surgery, and but two for the country doctors. In other places surgeons of the first class were required to take but three years, while those of the second class attended some lectures, principally on anatomy, and served for a short time in a military hospital. It was not until the second half of the century that the standing of physicians and surgeons became equalized.

On account of the Napoleonic wars, of which Austria was so often the seat, the surgeons of Southern Germany first attained prominence, and Kern, Wattman and Schuh strove to establish the identity of German surgery and to free it from French influence. In this they were aided by the school of Würzburg, which turned out Walther, the father of modern surgery in Bavaria, the Textors and Jaeger who contributed largely to the surgery of bones and joints, and Hesselbach whose valuable work in connection with hernia is recalled by "Hesselbach's triangle." The school of Göttingen did similar service through Langenbeck, the elder, and Stromeier, famous for his tenoto-

mies and his plastic and orthopædic work. His splint is much used in Germany. Berlin added such men as Rust, Graefe the elder, Dieffenbach, who first tenotomized the eye muscles for strabismus, and Middeldorpff, who introduced the galvano-cautery and the splint bearing his name. Prominent among the writers are Chelius and Hueter, the authors of valuable text-books. Linhart, whose operative surgery has been much used. Pitha and Lücke, successively co-editors of Billroth in the exhaustive *Deutsche Chirurgie*, and many others. Of recent date are Bruns who developed laryngology and whose name is given to absorbent cotton in Germany, and Langenbeck, best known through his numerous and brilliant pupils, as he did not write much. He was a splendid operator and improved surgical technique wonderfully. To these should be added Simon, eminent as a gynaecologist and who did the first nephrectomy. Our own Dr. James probably did the first one in this city. Also Volkmann, who introduced antisepsis into Germany, extensively worked in diseases of bones and joints, and with whose operation for hydrocele you are familiar. Billroth, Langenbeck's most illustrious pupil, heads the list of German surgeons. His indefatigable industry equalled or even excelled that of John Hunter, and yet he found time for music and society. As a public teacher he did not draw, but as a preceptor, writer, and operator, he had no superior. He was the first to operate for cancer of the larynx and pylorus and his treatise on surgical pathology has had a profound influence on surgery.

With the nineteenth century, two new countries entered into surgical history, Russia and the United States. In the former, there are but two men of note—Pirogoff, familiar through his amputation, who was driven out of his chair because he attempted to improve the rottenness of the Russian army and hospital officials, and Szymanowski, whose name has been given to a saw for resections.

This brings us to our own land. The earlier practitioners were "ship surgeons," who settled here, and, in New England, the clergy. Later on, most physicians were educated in Edinburgh. The first medical school was in Philadelphia, and there was but one surgical work published prior to 1800. With the beginning of the century we find the two Warrens, of Bos-

ton, and Physick, of Philadelphia. The latter wrote little, but contributed the seton in ununited fracture, and washed out the stomach with a rubber tube. Dorsey brought out the first American text-book on surgery, McDowell inaugurated ovariotomy, Rogers excised both upper jaws, while McGill tied both carotids; Gibson did Cæsarean section twice on the same patient, tied the common iliac and called attention to ruptures of the axillary vessels in reducing dislocations of the shoulder. The manipulative method for the reduction of luxations at the hip was introduced by Nathan Smith, and he first trephined the long bones for abscess. His splint is familiar to you. Valentine Mott was the leading man of the second quarter of the century. He was a very popular teacher, removed the clavicle for sarcoma, and performed 137 major ligations, among them that of the innominate. Rodgers wired ununited fractures and did osteotomy for ankylosis at the hip, and you are acquainted with Buck's adhesive plaster extension. Of the Philadelphia surgeons, the best known were McClellan, Norris, Horner and Barton, the latter being associated with his bandage for the jaw and the fracture at the lower end of the radius that he described.

Toward the close of this period a new epoch was inaugurated by ether anaesthesia. While there may be a doubt whether the credit for the discovery belongs to Morton, Jackson or Wells, that for its introduction is certainly due to Warren, Hayward and Bigelow, who tried it and published their experience. The latter surgeon has also made America famous by his revolution in lithotrity, which he called *litholapaxy*, and by explaining the mechanism of the ileo-femoral ligament in the reduction of hip luxations. The surgeons of the second half of the century are or will soon be familiar to all of you. They belong to us, not to history, even if they have passed away. Such are Willard Parker, Marion Sims, James R. Wood, Frank Hamilton, Van Buren and Sands, of New York; the two Atlees, Goodell, Gross, father and son, Pancoast and Agnew, of Philadelphia, and many others.

We have thus run over surgical history, incompletely and imperfectly, it is true, from the time of the ancients to our own day. We have seen the wonderful strides it has made during this century, and the impression may be forming in

some of your minds that it has reached perfection. Far from it. The discoveries and progress of the age have just opened the door for a future in which, I trust, we shall all participate, and each in his own way contribute his mite to the advancement of the noble art and science of surgery.

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### SURGERY OF THE KIDNEY.

BY J. M. LEE, M.D., ROCHESTER, N. Y.

(Read at the Southern Association Meeting, St. Louis, Mo., November 12, 1895.)

THIS clinical contribution to the surgery of the kidney is based upon the experiences derived from the treatment of six cases of floating kidney, seven of pyonephrosis, and three of nephrolithiasis. Nephorrhaphy was performed six times, nephrotomy six, nephrolithotomy three, and abdominal nephrectomy once.

It is not my intention to occupy the time of this learned body by an extended report of the history and treatment of each of the sixteen patients. I will give briefly, however, an illustrative case of each type of the disease, the technique employed in the operations, together with certain conclusions.

CASE I.—Nephorrhaphy.—Mrs. H. G., of Fort Collins, Colo., æt. 28 years, married and the mother of three children, presented herself for examination May 6, 1891. About two years before she noticed in the right hypochondriac region a tumor which was very movable and painful. She consulted three leading Colorado surgeons, who gave different opinions as to the nature of her disease. One believed she had an ovarian tumor with a long pedicle, while the other two diagnosed her malady as impacted feces and wandering spleen, respectively.

When I first saw her the tumor was about six and one-half inches long, by four inches thick, and somewhat resembled a kidney. The concave surface bore the regular outlines, but the opposite border was irregular and the organ very movable. It could be pressed down to within an inch of the anterior superior spine of the ilium, back under the ribs and across the median line. The urine was normal, and the symptoms present

were doubtless due to the displacement of the kidney, rather than to disease in its substance.

She entered the hospital May 28, 1891, and the following morning nephrorrhaphy was performed. The patient was placed on her sound side, over a hard, round pillow, so as to increase to its limits the costo-iliac space on the side of the operation. The twelfth rib was located and the incision begun half an inch below its lower border and close to the outer edge of the erector spinae muscle, and continued downward and forward three and one-half inches toward the crest of the ilium. There was not much haemorrhage; only two or three vessels required the ligature. The circumrenal fat was broken through by the fingers, and the fibrous capsule of the kidney incised lengthwise two inches, and turned back on both sides for half an inch, so as to form two flaps. Four silk-worm gut sutures were passed down through the skin, muscles, lumbar aponeurosis, and the dissected flap of the capsule on one side, then made to perforate the corresponding tissue of the other. Drainage tubes were placed in the angles of the wound, and the deep sutures tied down. The skin was approximated by interrupted stitches of catgut and the dressings applied. She suffered no shock, and the highest temperature recorded during her recovery was 99.8° Fahr. The wound healed by the first intention, and she was discharged from the hospital the fourth week in good condition.

An examination five months subsequent to the operation showed the kidney to be in proper position and firmly fixed. The enlargement of the organ was less marked, and gave her no inconvenience. Her troublesome symptoms disappeared, and she remained well until October 25, 1892, when I was again called to see her. She informed me that she had skipped two menstrual periods, that there had been considerable nausea and vomiting, and she believed that she was pregnant. Examination per vaginam showed this to be true. The kidney was found well attached in its normal position, and its enlargement was much less. I felt sure, if the pregnancy were allowed to advance, that in all probability the kidney would again be displaced, and her condition made as bad, or worse, than before. Dr. J. W. Buell, of Rochester, was therefore called in council, and after the case was considered from all standpoints, we determined that an abortion would be justifiable, and it was imme-

dately performed. She recovered promptly, and remains well at the present time.

CASE II.—Nephrotomy.—Miss M. H., æt. 23, occupation ladies' maid, through the kindness of the late Dr. Dayfoot, was placed under my care March 30, 1890. She gave the following history: Was taken ill a year before with what some of her attending physicians diagnosed malarial fever and others phthisis. Examination revealed the presence of a tumor, about eight inches in diameter, in the right hypochondriac region, and it was easily traced back under the border of the twelfth rib—the position normally occupied by the kidney. The amount of urine secreted within twenty-four hours was but thirty ounces, and it contained a large quantity of pus and considerable albumin. Her temperature varied from 100.5° Fahr. in the morning to 102.5° in the evening. She had profuse night sweats, and decreased in flesh from 123½ pounds to 75 pounds. Pyonephrosis was the probable diagnosis, but it could not be positively established; therefore a tentative operation was begun through the right linear semi-lunares and finally completed as abdominal nephrotomy. When the kidney was reached, a rectal trocar was plunged into the organ, and a pint of dark, greenish pus evacuated. It was then opened between two pairs of artery-forceps, and the sac drawn through the wound and thoroughly washed out with a 10 per cent. solution of peroxide of hydrogen. The cavity was carefully dried with moistened bits of absorbent cotton, and the sac stitched to the abdominal wall and packed with gauze, which was finally removed and drainage established by rubber tubes inserted at the angles of the wound. Within six months the pus and albumin entirely disappeared from the urine, she gained thirty-nine pounds and remains quite well.

So far as I know, this is the first nephrotomy performed through an incision in the linea semilunares, and it probably is impracticable in other than a thin subject with a large sac. However, in this case, owing to extensive adhesions, I was unable to diagnose between empyema of the gall-bladder and pyonephrosis; so I made the incision through the abdomen instead of the loin, as is usual.

CASE III.—Nephrolithotomy.—Mr. ——, Penn Yan, N. Y., Dr. Sampson's patient, presented himself for examination March

12, 1898. He had suffered much pain in the left side over the kidney during the previous two or three years, had lost flesh and strength and was entirely incapacitated for business. Examination revealed a hard tumor in the renal region, and the exploring needle showed the presence of a calculus and considerable pus. The kidney was reached through the lumbar route, and a branched stone extracted which weighed three-quarters of an ounce. Hundreds of diminutive calculi were washed out with peroxide solution, the cavity was carefully drained and the patient made a good recovery.

**CASE IV.—Abdominal Nephrectomy.**—Mrs. —, æt. 42, married, presented herself for examination May 3, 1894. There was a hard unyielding tumor in the region of the right kidney which measured eight or nine inches in diameter. It was immovable, not appreciably fluctuating, yet the exploring needle showed it to contain a thick, greenish pus, a deposit of which was persistently present in the urine. This afforded presumptive evidence that the disease was pyonephrosis, but a positive differential diagnosis between this malady and empyema of the gall-bladder could not be made. Then, even if it were a diseased kidney, the great size of the tumor made it more prudent to select the abdominal rather than the lumbar route for its removal.

The operation was performed at the patient's home, Genoa, N. Y. Her family physician, Dr. J. W. Skinner, and two brave farmer women were my only assistants. The incision was made in the linea semilunares, and when the mesocolon was torn through the pus sac of the enlarged kidney was brought into view. It was evacuated, the hopelessly diseased organ carefully enucleated from its cellular bed, the pedicle secured by strong braided silk ligatures and the kidney cut away. A gauze drain was introduced, the opening in the mesocolon brought together by a running catgut suture to within a convenient distance of it and the abdomen closed. The gauze was removed on the third day, and the patient recovered promptly, as did all of the sixteen cases referred to at the beginning of this article.

However, in one of the nephrolithotomies in which the kidney had degenerated from extensive suppurative process, a urinary fistula of slight inconvenience remains, two years sub-

sequent to the operation; and, although the patient is able to do manual labor, it is likely that nephrectomy will yet be called for. One of the nephrotomies died from sarcoma, which developed in the affected kidney eighteen months after the operation. The remainder of the cases are apparently well at the present time.

Although the operation known as nephrotomy is several centuries old, and was recommended by Hippocrates, but little is said of it until we come down to the writings of Velpeau, as revised by Mott in 1847. Even this distinguished surgeon believed that the operation could be proposed only in a small number of cases, as in those in which the flank became the seat of an evident fluctuation.\*

Gross,† in 1872, says this operation can be thought of only when the tissues of the loin are partially destroyed by ulceration. Homes,‡ in 1881, says that a pyonephrosis should be opened when the tumor points and the diagnosis is perfectly clear. Thus it is seen that distinguished surgeons copied the ideas of one another for many years, and made but little, if any, original investigation of the treatment of pyonephrosis and kindred diseases until the present decade.

The recent works of our own distinguished Helmuth, Agnew, Ashurst, Wyeth, Heath, and especially Fisher, Treves, and Greig Smith, fairly indicate the present status of this branch of surgical work. To-day it is perfectly proper to cut down through healthy tissues, however thick, strip the kidney of the surrounding fat, make numerous exploratory punctures with the needle upon the line of its curvature, or even incise the organ so as to pass the fingers well into the pelvis of the kidney if necessary. If there be an accumulation of pus in the kidney, the tissues of the loin may be divided, the capsule incised and stitched to the muscles, or the organ removed entire, as may seem best for the patient.

A few years ago it was common practice to perform nephrectomy in most cases of pyonephrosis; but now, owing to the better results obtained, this method of treatment has given way to the more frequent practice of nephrotomy. This operation

\* See Velpeau's *Operative Surgery*, vol. iii., page 1019.

† Vol. ii., p 710.

‡ Vol. ii., p. 751.

has a very low mortality, and in case suppuration continues to be profuse and the patient does not improve, nephrectomy can be as well or better performed at a later period. Again, where the patient is greatly emaciated and debilitated nephrectomy is contraindicated; but nephrotomy can be done and the patient's condition improved, when the graver operation can be carried out if found necessary. In a large proportion of cases, however, nephrotomy is preferable, as all the secreting substance of the kidney remains to assist in the elimination of the urine. Not infrequently both kidneys are more or less diseased, and if the secreting substance yet remaining to one organ be removed, the other, in its impaired state, may not suffice to do the work which both are able to perform. Indeed, many a patient has lost his life by the removal of one kidney, when the other was too much involved to carry on the work of both.

Four or five years ago extirpation of diseased floating kidney was a more common practice than to-day. With our present knowledge it would be bad surgery to remove a floating kidney, however grave the symptoms might be, provided a considerable portion of the organ is sound. Even when there is quite extensive disease, it is better practice to suture the kidney in place, and leave the more serious operation of extirpation as the last resort.

As to nephorrhaphy, the operation is performed to-day substantially as when introduced by Hahn, of Germany, in 1881. The only improvements made are in the use of better suture materials, and the more thorough preparation of the kidney for their employment. At times surgeons have expressed preferences for silk, silk-worm gut, silver wire, kangaroo tendons, or catgut. The truth is, it makes but little difference which one of the first three is used, but the last two do not sufficiently resist the unusual absorbent qualities of the kidney to be depended upon as the principle sutures. The other more serious question which engages the profession at present is:

How shall the kidney be prepared for the sutures?

Five methods are employed with more or less success:

1. The circumrenal fat contiguous to the wound, either freshened or not, is transfixated by the needle and united to the bottom of the incision.

2. The adipose tissue is removed from the surface of the kidney and the sutures are passed through its fibrous capsule.

3. The kidney is exposed as above, and the sutures are then passed through its parenchyma so as to bury them in the organ a quarter of an inch.

4. The capsule proper is divided longitudinally with the kidney two and one-half inches, stripped back each way half an inch, and the sutures are passed through the parenchyma just outside of these flaps.

5. The sutures are passed only through the flaps raised as above.

The first method should not be used, as only fatty adhesions are secured and relapses often occur. The fourth and fifth yield the most permanent results and possess the advantage that if stitch abscess form in the parenchyma of the organ it will discharge through the wound instead of developing pyonephrosis.

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#### A COMPARATIVE STUDY OF THE UMBELLIFERÆ.

BY CHARLES MOHR, M.D., PHILADELPHIA.

(Lecture given in the Hahnemann Club Course, at the Hahnemann Medical College, Philadelphia.)

THE natural order, Umbelliferæ, the parsley family, contains a number of interesting plants whose properties and uses are of considerable importance.

In this order are included the well-known aromatic stimulants and carminatives, *Carum Parui* (Caraway), *Pimpinella Anisum* (Anise), *Fœniculum Dulce* (Sweet Fennel), *Anethum Graveolens* (Dill), *Coriandrum Sativum* (Coriander), *Daucus Carota* (Carrot). In all these the active properties reside in a volatile oil found in the fruit, commonly called seed. The caraway, anise, and fennel are the most agreeable, and are often employed by the cook and confectioner as flavoring agents. In ordinary medical and domestic practice, all these aromatic stimulants are used, either as adjuvants or correctives of nauseating and griping properties of some medicines, or as remedies for the relief of flatulence and colicky pains. The carrot is also employed as a diuretic in suppression of urine and painful micturition, also in dropsies, and as a local stimulating application in cracked nipples and ill-conditioned sloughing sores.

None of these umbelliferous plants or their seeds have received any attention by provers; hence there has been no homœopathic employment. The star-anise, *illicium anisatum*, nat. ord. magnoliaceæ, must not be confounded with the pimpinella anisum, although the fruit and seeds of both contain a chemically identical oil (*oleum anise*). The illicium has been proven by Franz and Mure, who experienced qualmishness, nausea, pains in stomach and intestines, borborygmi, bilious stools, retention of urine, violent erections of penis and pollutions, pains in chest with catarrhal symptoms and cough, and pressive, drawing, and tearing pains in joints. Clinically, this anise has been found useful in homœopathic practice in the colic of infants, and in coughs with pain at the third costal cartilage of the right side; sometimes also of the left side, especially in old drunkards. According to Hering, *illicium* is useful and compatible after *aconite* and *bryonia* in coughs with hæmoptysis.

In connection with the joint pains noted by Franz and Mure, it may be well to state here that *anisic acid*, obtained by oxidation of *anethol*, a constituent of anise and fennel, has been found useful in acute articular rheumatism, and the drug possesses antipyretic and antiseptic properties. And this was known to the ancients, for in the school of Salernum, which flourished in the ninth century, the following powers are attributed:

“Fever in its presence never stays,  
It kills poison and the stomach frees.”

We come next to *petroselinum sativum* (parsley) and *apium graveolens* (celery). Parsley and its ally, celery, are largely cultivated for culinary purposes. The odor and taste are agreeable and aromatic, and the fruit and seed resemble in their action those of caraway, anise, and fennel. Petroselinum and apium have greater repute as medicines. In old-school practice parsley is a popular remedy for engorgement of the mammae and to dry up the milk in threatened mastitis. In these cases it is applied locally. In decoction of the root, strangury produced by cantharides and turpentine, and the painful micturition of gravel, are relieved. Infusion of the dried leaves and the juice have been utilized in the treatment of gonorrhœa, periodical fevers, and neuralgia. *Apiol*, contained in the fruit of the parsley, in combination with other substances, in doses of 5

minims in capsules, has been highly lauded in the treatment of amenorrhœa, scanty and foetid menses, and dysmenorrhœa, especially in all cases for which direct emmenagogues are considered appropriate. The larger doses of apiol have caused intoxication, with ringing in the ears and severe frontal headache (like quinine).

Celery juice and the infusion of the plant or roots have been employed for the same diseases as parsley, and also in the treatment of chronic bronchitis, and locally as a stimulant and anodyne poultice to contusions and glandular swellings.

*Petroselinum* in a tincture made from the whole fresh plant has a short pathogenesis, but the symptoms of the genito-urinary system are pronounced. Frequent and sudden desire to urinate; crawling behind the fossa navicularis; agglutination of the urethral orifice; milky urethral discharge; priapism without curvature of the penis; and drawing and sticking pains in the fossa navicularis, changed to biting and cutting after urination, are the recorded and corroborated symptoms. Acute inflammation of the urethra and bladder, gonorrhœa, retention in children, who fairly dance with pain when the sudden urging to urinate comes, are the conditions cured by petroselinum when the quoted symptoms have been present. Hering in *The Guiding Symptoms* reports a number of cases of intermittent fever cured by petroselinum after the failure of quinine. The cases were mostly quotidian, with marked periodicity, especially when flatulent dyspepsia, heat in stomach, nausea and vomiting were prominent symptoms during the paroxysms in men. The women benefited were plethoric with a history of painful, scanty, or absent menses with lumbar and inguinal pains and aches.

*Apium graveolens* in tincture made from the seeds has only received a fragmentary proving. The symptoms elicited were prominently, empty eructations, heartburn, spitting up of food, gone feeling of stomach relieved partially by eating, sudden urging for stools which were frequent but well-formed, retention of urine, itching blotches of skin in various parts of body, chill in back, heat of vertex, intermittent burning of thighs with rawness of skin on inner side, broken sleep, throbbing headache. Clinically, the retention of urine has been corroborated, and *apium graveolens* has been found useful in excessive discharge

from granulating ulcers, when constriction over sternum with drawing through to back on lying down were present.

We will consider now the umbelliferous plants whose active properties are due to fetid gum-resins. Here we find *narhex asafætida* (*asafetida*), *dorema ammoniacum* (*ammoniacum*), and *ferula galbaniflua* (*galbanum*). Notwithstanding its intensely alliaceous odor and bitter acrid taste, *asafetida* is used as a condiment in India and Persia, just as we find the aromatic umbelliferæ used in Europe and America. Phosphorus, but more especially sulphur oil, is contained in *asafetida*, and to the latter constituent the value of the drug doubtless depends. In the Old School, by some, *asafetida* is considered the chief anti-spasmodic, and as such is used frequently in the treatment of hysteria, infantile convulsions, epilepsy, asthma, laryngismus stridulus, pertussis, colic, etc. Among adults, the aged, the hysterical, and the hypochondriacal, are most readily brought under its beneficent effects, especially when the subjects are constipated.

In the school of Hahnemann *asafetida* has been proven, but is not often prescribed; not as often as it should be. We find under this drug impairment of digestion; burning in fauces and œsophagus; pain, fulness and oppression of the stomach; alliaceous eructations; sensation of ball rising from stomach along œsophagus to throat; abdomen distended with flatus; wind passed from the bowels very foetid and disagreeable; frequent desire to evacuate thin and watery stools; urine acrid, and passed with sensation of burning; pulse quickened; spasmodic tightness of chest, lungs cannot expand; flying pains in head, with giddiness; burning and pressive pains in eyes; various nervous and hysterical phenomena; increased sexual desire, with irritation of the glans penis, and in women anticipating menstrual discharges with uterine pains.

Therapeutically, *asafetida* has been used in the practice of homœopathy in hysterical manifestations, in deficient lacteal secretion in nursing women, in tympanitic distension of the abdomen, in orbital neuralgia and iritis. Henry N. Guernsey gives hyper-sensitiveness as one indicating symptom in all these cases, and Farrington lays stress on suppressed discharges as a cause of the distressing symptoms when *asafetida* is to be used. Dr. Holcombe and others have successfully used this drug in

treating syphilitic and scrofulous ulcerations, especially of the tibia, when there is an intolerance of any kind of dressing.

*Ammoniacum* has effects similar to, but less powerful than those of asafetida. It is prescribed by old-school practitioners principally in chronic pulmonary affections as a stimulant expectorant, or to relieve old asthmatics with bronchorrhœa. It has occasionally proved beneficial as a resolvent application to glandular enlargements and indolent arthritis.

Dr. Buchner has given the homœopathic school a good proving of *Ammoniacum*, and his symptoms have been corroborated by others. It is noteworthy that increased secretions of the mucous membranes, especially of the eyes, throat, bronchi and intestines, were produced, along with disturbances of vision, and quite violent and persistent pains in the muscles and joints, especially of the lower extremities; and febrile symptoms with disposition to sweat were also induced. Pains in the belly with borborygmi; dull, shooting and jerking pains in cæcum, worse when turning on right side; loss of appetite, inclination to vomit were also produced.

Therapeutically, the principal uses of *ammoniacum* have been in the treatment of amblyopia and pulmonary affections of old people too feeble to raise mucus, and always worse in cold weather. The pathogenesis suggests the probability of *ammoniacum* proving a useful remedy in rheumatism and gout, and perhaps in appendicitis.

*Galbanum* partakes of the nature of the other gums, affecting the nervous system, like asafetida, and the vascular system, like *ammoniacum*. Applied to the skin it causes a papular eruption, and ulceration, if the true skin is exposed.

Therapeutically, it has rarely been used alone, generally being combined with asafoetida. This gum-resin should receive a proving, especially to determine its influence over the uterus, and to note its effect on the locomotor system, as amenorrhœa, chronic rheumatism and weakness of the legs in rickety children have been reported cured under its use.

Closely allied to the gum-resins is *eryngium sumbul* (Sumbul). This plant owes its medicinal properties to a volatile oil, balsamic resins, and sumbulic acid. It possesses antispasmodic properties, and is a nervine stimulant like valerian, to use the parlance of the old school. Its chief employment, therefore,

has been in the treatment of low fevers, cholera, delirium tremens, epilepsy, chorea, hysteria and chronic pulmonary affections. Latterly it has fallen into disrepute.

Quite an extensive symptom list appears in Allen's *Encyclopædia*. Many of the symptoms resemble those of *asafœtida* and of *moschus*. Clinically few of them have been corroborated. This drug should receive more attention at the hands of homœopathists, especially in the treatment of neuralgia and the ill effects of pollutions. Phillips speaks of the great rapidity with which a few doses of *sumbul* will cure severe facial, sciatic or ovarian neuralgia, especially in people of quick and lively nervous temperament. In the restlessness and sleeplessness of pregnancy, and the insomnia of chronic alcoholism he finds in *sumbul* an efficient tranquilizer.

We will now consider the more poisonous of the umbelliferæ. These include *œthusa cynapium* (fool's parsley), *œnanthe crocata* (drop water), *phallandrium* (five-leaved water hemlock), *eryngium aquaticum* (button snake root), *hydrocotyle asiatica* (Indian pennywort), *cicuta maculata* (spotted parsley), *cicuta virosa* (water parsnip), and *conium maculatum* (spotted hemlock).

Authorities differ as to the toxic properties of *œthusa*, yet we may accept as well founded the reported convulsive symptoms, somewhat epileptic in character, and tetanic rigidity of the lower jaw; headache, with red face and inflamed eyes and œdematosous cheeks. The provings showed marked gastro-intestinal irritation, with catarrh. Hahnemann, in the *Lesser Writings*, says it specifically produces imbecility. Therapeutically, this drug has been used most in cholera infantum. Henry N. Guernsey esteemed it highly in this complaint, and gave as special indications anguish and crying; disposition to jump out of bed or to escape from the room; the anguish of face accompanied by the linea nasalis; regurgitation of food an hour after it has been taken; swelling of external glands, with lancinating pains; startings in sleep; heat without thirst. It has also been found useful in vomiting of curdled milk in babies who have also a yellow-greenish diarrhoea; the urine increased, pale in color and sweetish in odor. The remedy has also been used in strumous ophthalmia, and Hahnemann took one grain of the extract prepared by himself when he was distracted and incapable of mental labor from overwork, and was greatly benefited.

*Enanthe crocata* was considered by Christison as the most energetic of the umbelliferæ. Its special interest lies in the fact that the toxic effects very closely resemble epilepsy, and experiments on animals showed inflammation and softening in the medulla oblongata and its neighborhood. This drug needs a thorough proving. So far its use has been confined to the convulsions of children suffering with eruptive diseases; the epileptiform convulsions of pregnancy, with albuminuria; and the tickling cough of bronchitis, with rattling in the lower chest, and expectoration of thick, heavy, white and yellow sticky sputa.

*Phellandrium* acts similarly to its congener, œnanthe, and at one time was held in high esteem for chronic suppurations occurring in the lungs and elsewhere. Provings are published in Allen's *Encyclopædia*. More provings should be made, especially by women, as we find their sexual organs and mammae much disturbed. Clinically, soreness of the lactiferous ducts, violent stitches through the mammae, extending to the back between the shoulders, then downward into the right side of the sacrum, have been symptoms reported cured. Dr. Dudgeon cured several cases of long-lasting headaches with the following symptoms: Pain like a heavy weight, a stone, or a lump of lead on the top of the head; aching and burning in the temples and above the eyes; pain in the eyes, with congestion of the conjunctiva; lachrymation, and intolerance of light and sound.

*Eryngium aquaticum* has been proven, the head and eye symptoms being pronounced and severe, with marked genito-urinary phenomena. The urging to urinate was frequent; passed drop-wise, with stinging and burning back of the glans-penis, and sensation as if urine remained behind; sexual desire suppressed, then excited with lewd dreams and pollutions; discharge of prostatic fluid from slight causes. These symptoms have been verified in practice in results of masturbation, and frequent seminal emissions, day and night, from injuries.

*Hydrocotyle* recommended for leprosy in both East and West Indies, was tried in Paris with negative results in the leprous cases but its trial afforded an opportunity of watching its effects and studying its characteristics. The pathogenesis you will find in Allen. It seems to have a special affinity for the

sexual apparatus of woman, and an unquestionable action on the skin. It should be further proven on women. The symptoms which have been verified in the treatment of the sick are: Depression, heaviness and dull feeling throughout the system; bruised feeling in all the muscles; weariness with gloomy thoughts; vertigo; dull pain in the ovarian region; severe labor-like pain in the uterus and appendages; redness of the cervix; redness of the vulva and vagina; leucorrhœa; heat in the bottom of the vagina, with pricking and itching at its orifice; erysipelatous redness of the skin; circular spots slightly raised, scaly edges; yellowish spots on legs; pustules on chest; papules on face; pricking and itching in different parts. Of diseases reported cured we find: chronic eczema, acne, lepra tuberculosa, lupus exedens, granular ulcer of cervix uteri, pruritus vaginæ, and cystitis.

*Cicuta maculata* should be proven. We have only the toxic effects published in Allen's *Encyclopædia*. These cases show most distressing spasms, vomiting, violent colicky pains, intermittent, slow and thready pulse, staring eyes and widely dilated pupils.

*Cicuta virosa* is one of the drugs proven by Hahnemann. His symptoms, and those of fellow-provers, with the toxicological effects observed in poisoning cases, make quite an array. From poisoning cases we learn that cicuta causes tetanus as manifestly as strychnine, but it affects the brain as profoundly as it does the cord. The recorded and verified symptoms are: Face red, or cadaverously pale and drawn; skin of face and hands covered with elevated, dark-red, discrete then confluent vesicles, burning to touch; desquamation; coldness, heat, and sweat on abdomen at night; jerking, sticking and trembling of upper and lower extremities and fingers; weakness of knees and back, cannot stand; tearing and jerking in coccyx; delirium; grotesque dancing, singing and shouting; excitement and apprehension; distrust; loss of ideas, torpor and stupefaction; convulsions with great distortion of limbs, head bent back, opisthotonus, and unconsciousness; spasms of all muscles, blue lips, bloody froth from mouth; vertigo, reels and falls to ground; staring eyes, pupils dilated and insensible, or contracted and then dilated; sensitive to light; when standing objects appear double, or approach and recede; hearing diffi-

cult; palpitation, intermittent and weak pulse; oppression of breathing, tightness of chest and heat of chest; white sores on margin of tongue painful to touch; salivation; dry throat impeding deglutition; thirst; longing for coal and eats it; hic-cough; burning, pressing and throbbing in stomach; pit of stomach raised to size of fist; abdomen distended; rumbling and roaring of wind; diarrhoea 2 to 5 A.M.; irresistible desire to urinate; urine spurting and involuntary; sore pain beneath penis extending to glans; testicles drawn tightly against abdomen. Clinically these symptoms have been the indications for the use of cicuta in the treatment of tetanic, epileptic and choreic convulsions; cerebro-spinal and basilar meningitis; repercussion of eruptions; melancholia following concussion of brain; post-typhoid insanity; torticollis; spasmodic strabismus; deafness of old people; vertigo; gastralgia; spasms of oesophagus; hic-cough and belching; indigestion; worms; chronic impetigoes; chronic eczema barbae; adenitis.

*Conium* is a drug of historic interest, especially since it has been determined that it was the conium and not cicuta with which political offenders were executed, and that it was the spotted hemlock that killed Socrates. Plato describes his death thus in his *Phædo*: "Socrates, having walked about, when he said that his legs were growing heavy, lay down on his back; for the man so directed him. And at the same time he who gave him the poison, taking hold of him, after a short interval examined his feet and legs; and then having pressed his foot hard, he asked if he felt. He said that he did not. After this he pressed his thighs; and thus going higher, he showed us that he was growing cold and stiff. Then Socrates touched himself, and said that when the poison reached his heart he should then depart. But now the parts around the lower belly were almost cold; when uncovering himself, for he had been covered over, he said (and they were his last words), 'Crito, we owe a cock to Æsculapius; pay it therefore, and do not neglect it.' 'It shall be done,' said Crito, 'but consider whether you have anything else to say.' To this question he gave no reply; but shortly after he gave a convulsive movement, and the man covered him, and his eyes were fixed; and Crito, perceiving it, closed his mouth and eyes."

It is thus seen that conium caused death by gradual asphyxia,

the paralytic phenomena occurring from below upwards. Later experiments, especially those of Dr. John Harley, show that full doses put the motor centres to sleep, and if the experimenter use his legs the effects are observed most markedly in the lower extremities, and we have difficult walking, with desire to lie down, or a tendency to tremulous weakness. If, however, the prover remains at rest, the effects are first noticeably observed in the eyes. There are sluggish accommodation, with vertigo on attempting to adjust the focus; dilated pupils; diplopia; objective and subjective ptosis. These visual phenomena imply paralysis of the third, fourth and sixth cranial nerves. Consciousness is not affected, and sensory nerves rarely or slightly.

As with all other drugs, the provings made by Hahnemann give us finer distinctions, and enable us to apply the drug therapeutically on scientific principles. Thus we find in Hahnemann's pathogenesis: aversion to people being near, and yet fears to be alone; inability to sustain mental effort, or to understand reading; loss of memory; bursting headache in morning on awaking; intoxication from slightest alcoholic drink; vertigo when turning over in bed; deafness, hardened cerumen, which is blood-red; palpitation after drinking, after stool, and then intermittent pulse; dryness of larynx and crawling with irritation to dry cough; cough at night on first lying down, must sit up and cough it out (*hyos.*); cough in shocks, with sick stomach as if vomiting must occur, mucus detached with difficulty, and cannot be expectorated, must be swallowed (*caust.*); sticking pains through chest; knife-like thrusts through sternum to spine when sitting; clothes over chest feel oppressive; appetite lost; thirst; empty, sour eructations after eating; intermittent tearing and sticking pains in stomach and liver; constrictive band about hypochondria; sticking pains in rectum at stool; frequent watery diarrhoea with empty eructations and copious flow of urine; urination involuntary and frequent at night; dribbling of urine; in man sexual desire without erections; emissions easily excited; prostatic discharge from slightest causes, and without voluptuous thoughts; in woman itching deep in vagina; white, acrid, flowing leucorrhœa with colic before discharge and weak back; suppressed menses; hardened mammae (especially the right), with sticking pains, more about nipples.

The above symptoms have all been frequently verified, and conium has been used very effectively in the organic affections of lymphatic people, especially in children and old women. Hypochondria from excessive venery, or more particularly with enforced abstinence from sexual intercourse; adenitis; strumous ophthalmia; vertigo of old people who use tobacco; cataract; deafness, with painful hearing; asthma; pertussis; gastralgia with stomach cough; cancer of stomach or liver; diseased glands of the mesentery; diarrhoea alternating with constipation in the aged; paralysis of the bladder; uterine haemorrhage; dysmenorrhœa; pruritus vaginæ; cancer of the cervix and mammary tumors are among the diseased conditions that have been cured by the application of conium when the symptoms have indicated this medicine.

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#### THE NON-MEDICINAL TREATMENT OF GASTRIC FEVER.

BY C. H. HOFMAN, M.D., PITTSBURG, PA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania.

THIS part of the treatment of gastric fever is touched upon quite lightly in text-books and is in the main rather unsatisfactory.

The most prominent symptoms that usually present themselves, and the most distressing to the patient, are thirst and the inability to retain whatever is taken into the stomach; and while remedies can and will act, we must not interfere with their action, and at the same time give the stomach as much rest as possible and not contribute to keeping up the very condition we are trying to cure.

It has been my experience that remedies act comparatively slow in this disease, and while we are waiting for the medicines to exert their curative powers the patient urgently demands relief from the symptoms that are to him the most distressing.

If the thirst is great and all fluids are rejected, it follows, of course, that we cannot allow the patient to take water by mouth. In these cases we generally find the mouth dry,

parched and feverish and the secretion of saliva practically absent. We may allow the patient to take small lumps of ice into the mouth and reject the water as the ice melts, but on no account to swallow it. If the mouth is dry and thirst not prominent, the patient may use as a gargle a mixture of two parts water to one of glycerine, and this, if repeated from time to time, will generally be found to be sufficient to help keep the mouth moist.

In addition to this, cold water applications to the epigastrium will be very useful, not only to keep down the thirst, but also to cool the burning which is so frequently experienced there. To do this a folded towel may be wrung out of cold water and placed upon the epigastrium and covered with a piece of oiled skin or another dry towel. The wet towel should be renewed as often as it gets quite warm. I may say here that it is surprising how soon this is in some cases. The placing of the cold, wet towel on the hot skin of the patient is often slightly disagreeable to him at first, but he soon experiences the relief it gives and will ask for a renewal whenever the towel gets warm.

In such cases where the vomiting is persistent a spice plaster, such as may be bought ready prepared, may be substituted for the wet towel, or a spice poultice which can be made by taking a tablespoonful of flour-paste (not flour, but true paste after it is made) and adding a teaspoonful of each of ground allspice and grated nutmeg, then mixing them and placing the mixture between two pieces of muslin and applying it as hot as can be comfortably borne. This poultice may be kept on several hours. The most efficient ingredient of this poultice seems to be the nutmeg, and I have frequently had nutmeg grated over a towel wrung out of either hot or cold water, as the case seemed to require.

To supply the fluid that the body requires and which cannot be taken into the stomach we must have recourse to enemas of warm water at a temperature of about 104°. Care must be taken that the water is not too cold, or it will either cause griping or will be rejected by the rectum. Should it be too hot an uncomfortable scalding sensation will be produced, and the patient will not submit to a repetition of the process. Four to six ounces every three or four hours should be sufficient.

To this may be added a tablespoonful of bovinine or liquid peptonoids to nourish the patient.

As long as the vomiting is marked the patient must, of course, be nourished as much as possible by rectal alimentation, taking care not to overdo the matter and so make the rectum irritable and unable to retain the injections. The subject of rectal alimentation, although of the greatest importance in this disease, will not be entered upon in this paper, as it was fully discussed on a former occasion by a committee of the Allegheny County Society (see *Transactions* of 1884, page 112).

Although, as a rule, the temperature of this disease does not exceed  $101\frac{1}{2}^{\circ}$  to  $102^{\circ}$ , yet in some cases it goes decidedly higher. In such cases the comfort of the patient will be added to, and the fever generally decreased by spongings of the body at more or less frequent intervals, as the case may require. Cold water is usually recommended for this; but it has been my experience that warm or even tolerably hot water is more efficacious and longer lasting.

Washing out the stomach with warm water may sometimes be useful, but I think it will be rarely found necessary in gastric fever.

The vomiting having been controlled by the medicines given, and the patient having in the meanwhile been fed by nutritious enemata, the question arises what to allow him to take by mouth, so as not to bring back the very condition that we have been combating. This question is a serious one, as the least error in diet will frequently bring on the vomiting again, and the patient be in as bad a condition as before, and even worse; for he is weaker than before, since the rectal enemata do not fully nourish a patient, and only serve to keep him alive until such time as he can take food by mouth. One patient within my recollection had a relapse lasting from four to six weeks from taking one ginger-snap, in spite of stringent orders.

Another problem is to vary the diet so that the patient will not tire of it; for no matter how good or how easily assimilable an article of diet may be, the too frequent repetition of it will often cause repugnance and even loathing, and, if persisted in, vomiting. We must, therefore, have a number of articles at our command, so that one may be substituted for another as soon as the patient seems to tire of it. It would be better,

even, not to wait until the patient expresses a distaste, but to carefully alternate such diet as we may be reasonably certain will be well borne.

It would be well to begin with a little water to be taken into the stomach. Sometimes cold water in small quantities— $\frac{1}{2}$ -ounce to 1 ounce—at a time is well borne; at others hot water with a pinch of salt is very grateful. I remember one case where a cup of hot water with a pinch of salt was the first thing to be taken into the stomach in forty-two days.

Having ascertained that the patient will retain water, the next step is to begin the cautious administration of liquid food. Of the liquid foods, my own preference is a teaspoonful or two of bovinine or liquid peptonoids, either alone or in a tablespoonful of cold water. This will be taken without repugnance for four or six days, when it would be well to vary the diet a little. A tablespoonful or two of rice- or barley-water—cold and salted—can be given, or some Valentine's or Wyeth's beef-juice, or we may give a little beef-tea. As the stomach is found to retain and digest these various articles, we may proceed a little further, and try some whey, either plain whey or wine whey, still retaining the articles spoken of for a variation of diet.

We may now go to something more substantial, and of all things it is my experience that buttermilk, almost ice-cold, is more grateful and refreshing than anything else. It is easily digested, and there are very few patients who object to it. Sweet milk I must utterly condemn, as I have too frequently found it to be vomited up in solid curds, showing that it was not digested.

Peptonized milk may not have this objection, but I have not had occasion to use it; for when it is thoroughly peptonized, as it should be in this disease, it gets bitter, and is distasteful to the patient. If left to the patient's choice, as should be done whenever safe, he will almost without exception prefer the cold buttermilk.

Another preparation of milk which is generally as easily digested as buttermilk, and has all the ingredients of sweet milk, is home-made koumyss. It may be made as follows: To a quart of fresh milk add two tablespoonfuls of maltine and about a quarter of a cake of compressed yeast, having

first liquefied it with some of the milk or with water. The mixture is put into patent-stoppered beer-bottles and put in a warm place—as behind the stove—for about eight or nine hours. The bottle may then be put on ice and used when cold.

Should the patient relish this, it may be prepared in larger quantities, and a little experience will soon enable one to make it properly. The bottle should open with a pop. A patient will tire of the buttermilk or koumyss a great deal less easily than of any of the other articles of diet, and may often be kept upon them for a week, or even two, without any serious objection on his part.

When it has been found that the patient is able to retain and digest liquid food for some time, we may gradually give him some more solid nourishment. For the first trial of this, my own preference is sweetbreads, parboiled and then broiled or fried in just enough butter to keep them from sticking to the pan. The patient is usually overjoyed to "set his teeth on something again," as it is generally expressed. Sweetbreads prepared in this manner will be found to be very acceptable, and easy of digestion. I hold them to be more digestible than beef, no matter how prepared. Raw oysters and clam broth may also be given now. We may even give them before the sweetbreads. Should the sweetbreads be found to agree, we may next in order try some scraped beef raw, or some home-made bread at least twenty-four hours old, spread with a little butter, or we may even try them in combination, making what is called a "cannibal sandwich." The scraped beef may be salted, and even slightly peppered, but we must be careful to cut the crust off the bread, as it is too rough to be put into a delicate stomach if it is insufficiently masticated.

At this point we wish to say that all food of a gritty nature is to be absolutely avoided for the same reason, and under this category are included all dry crackers, toast, rolled oats and wheaten grits; the two latter because they almost always contain portions of the hull, as can be seen when we make oatmeal tea and strain it through a cloth.

When we have brought the patient to the point when he can bear a scraped beef sandwich, the difficulties are generally over, and we may gradually allow him scraped beef sizzled on a hot

plate, a baked apple, broiled tenderloin beefsteak, roast beef, a lamb chop, chicken, a baked potato, game and fish that is not too fat, substantially in the order here given.

When he has been able to take these things without any ill effects, he may be put on ordinary food, taking care to warn him that he must be careful of his diet for a long time to come, and that he must avoid all fat and food difficult of digestion, as his stomach will remain weak for a long time, often for years, and any errors in diet may bring on another attack of the old disease.

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## WATER AND HEALTH.

BY CHARLES PLATT, PH.D., F.C.S.

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WHEN an unpleasant truth is forced too strongly upon us there is a natural tendency toward reaction. Ridicule and sweeping denial are convenient weapons with which to resist scientific advancement, and, in the eyes of a "worrying" public, a champion so armed is regarded as a true benefactor. There are, however, certain facts too vital to be so easily set aside and among them we can place the unsanitary condition of the average water supply.

That pure water is necessary to the preservation of the public health may be stated as an axiom when we consider the position which water occupies as food and the possibilities of its contamination. Constantly exposed to pollution, peculiarly fit for the carriage of germ life, and yet nearly always uncooked, water forms about two-thirds of our food while the remaining third is but diluted solids. Unless, then, we are prepared to deny *in toto* the germ-theory of disease, can we doubt the havoc wrought annually by this most important food essential? It would be difficult to cite an instance when the struggle against an unpleasant truth is more determined. People will use poisoned or dangerous supplies in face of the most earnest advice to the contrary and in face even of family deaths. We are told that "our family have used that well from time immemorial,

what was good enough for my grandfather is quite good enough for me," or, "the water is sparkling and clear and cannot possibly be contaminated," or, "that well has given good water so many years that I guess it will continue to do so awhile longer," and so on. The water is supposed to remain the same whatever the change in conditions and the only criterions of purity are the color and the taste, neither of value.

We need not refer to the long list of water carried diseases; suffice it to say that any germ disease may be foisted upon a community through its water supply and in the same manner carried from family to family. Typhoid fever is particularly of this class and were it the only one should still be sufficient to arouse the most active interest. Dr. John W. Hill has recently called attention to the fact that the typhoid death-rate of a city is the best test of the quality of its water supply and in evidence of this cites a comparison of European with American capitals. In the former, when the water is from guarded sources, the typhoid mortality varies from 2 to 16 per 100,000, while with us the upper limit is considerably above 100 and the lower seldom less than 30. Nor can we claim that typhoid fever is typically American, for with improved supplies the mortality is at once decreased. In Newark (N. J.), for instance, with a former typhoid fever death-rate of 45 to 61 per 100,000, a change in the source of public supply was followed by an immediate drop in the mortality from this disease to 15. It would certainly be difficult to point to a municipal reform of greater public interest. The problem is not always so easily solved, however, for in the ever increasing concentration of population there is a corresponding increase in the difficulties to be met. An absolutely pure supply is rarely available, a passable one is sometimes at hand, but in the majority of cases we must draw from a contaminated source and trust to subsequent purification. Methods of purification are indeed legion, chemical and mechanical processes crowd each other in their efforts to reach the public, but, except on a limited scale, there is one only truly practical method and that is careful sand filtration. House filters are more often dangerous than otherwise; this purification of our water must be accomplished before it is delivered to us. Not only this but its purity must be guarded through the city, as a cracked or strained water main will quickly undo the

work of the most elaborate filtering plant and an interrupted water pressure generally means increased mortality.

My purpose in the present article is to discuss private rather than public water supplies, the difference being not only of degree but also of kind, for while, as we have seen, the municipal problem is most often the purification of a more or less polluted water, the essential of a private supply is that it should be pure at the source.

Potable waters may be divided into four classes: 1, rain water; 2, surface waters; 3, subsoil or ground water; and 4, deep-seated or phreatic waters. The ultimate source of all of these being

*Rain Water.*—The rain as it falls dissolves certain gases from the atmosphere, and removes from it also any floating solid matter which may be present. It is evident, then, that the condition of the water on reaching the surface will depend upon the condition of the air through which it has passed, and that in the open country we may expect a comparatively pure result, while in the cities and in manufacturing districts the reverse will be true. Having reached the earth, the rain water may pass directly into lakes, rivers, etc., forming what is known as surface water. It may be absorbed and held by the upper strata of soil, forming subsoil water, or it may percolate deeply, accumulate in natural reservoirs far below the surface and form phreatic water. By suitable arrangements, however, collections from roofs, storage in cisterns, etc., the rain water may be preserved as such. New dangers of contamination are at the same time introduced by the washing into the storage vessel of the accumulations of organic matter from the eaves-troughs and water-pipes. The cistern itself may be open to pollution either from its imperfect construction whereby subsoil water enters through the sides or bottom, or by direct contamination from exposed tops. Now, as a rule, all three of these factors are in full play, and yet all may be easily guarded against. The pipes, in the first place, are best made of terra-cotta, or, when the choice lies between metal and wood, the former should be used. The water-ways should be kept clean, or, when not accessible, provision should be made for the diversion of the water that first passes through. The water, before entering the cistern, should pass through a filter box con-

taining alternate layers of gravel, sand and charcoal, whereby organic matter is removed, and, finally, the cistern is to be built with sides and bottom both sealed and with a close-fitting protected top. Attention to these simple points will insure a small supply, at least, of excellent water.

*Surface water* is rarely looked to as a source of private supply. We doubt our neighbors, and fear an unknown contamination higher up the stream. In deciding upon the condition of such a supply, however, the following may be considered: whether the stream is storm-fed, spring-fed or of composite nature; the character of the soil over which it has passed; the nature of the water-shed, whether populated, wooded or tilled; and, of course, the opportunities, direct and indirect, of pollution from sewage or manufacturers' waste.

Subsoil water, as already indicated, is that which collects near the surface, having proceeded directly from it. The zone is a variable one in depth and, though generally, is by no means always conformable with the surface contour. In character the water depends upon the nature of the soil and upon the local conditions, and when these factors are normal and sanitary the subsoil water will be of high degree of purity. The gases dissolved by the rain in falling are exchanged for the mineral matter of the soil. Organic matter is destroyed by filtration and aeration, and a cool, pure, sparkling water results. Such are the wells in new and sparsely-settled districts. But all this can be and is easily changed. From the barnyard, the outhouse, the kitchen, from the fields spread with fertilizers, and from a dozen other sources, the upper stratum of soil becomes impregnated with impurities, only awaiting a fall of rain to be carried into the subsoil water. Fortunately, in the downward percolation through an aerated soil the organic matter is removed and destroyed, and thus it is that the water entering at the base of a deep well will be pure no matter what the degree of pollution at the surface, always provided, of course, that there is not a deep-seated source of pollution, a cesspool, etc., in the immediate vicinity. The lack of aeration in the soil of cities is one of the chief arguments against the city well. If the well, then, presuming the soil to be in proper physical condition, were dug to a sufficient depth and if its water was derived entirely from that entering at the base, we would have

little reason to doubt its purity. The first condition is easily satisfied, the second is almost insuperable, for water will invariably find its way to the bottom of the well through the sides and from the top without having undergone the all-beneficial filtration and percolation, while even in closed wells the surface washings will make their way along the piping rather than through the soil itself. The writer has recently examined a so-called artesian well of considerable depth, which was contaminated from the surface in this manner. Granted the danger of surface pollution or of infiltration through the sides of the well, the position of the latter becomes of prime importance; but more often than not we find it at the kitchen door with both barn and outhouse in close proximity. The well should be geologically above all source of contamination, its position being such that the flow will be away from and not towards the reservoir, a condition to be satisfied by a determination of the dip of the underlying strata rather than by the surface contour.

The open well with wooden buckets represents the most dangerous use of subsoil water, the closed well with iron pump the most satisfactory; but in either case due attention must be paid to the location and cleanliness. We may add that it is not the mere presence of organic matter, even when in the form of animal excreta, that condemns the well; it is the proof given by this presence that the well is open to pollution and capable at any time of developing poisonous qualities. There is no evidence that the mere presence of a minute quantity of sewage is harmful in drinking water; but its presence is evidence that if at any time disease germs should pass into the sewage they would in turn enter the drinking water and thus poison the supply.

*Deep-Seated Water.*—Should the subsoil water find its way through the strata near the surface, it may percolate downward for a considerable distance before it again reaches a stratum sufficiently impervious to sustain it. Should this lower stratum be basin-shaped, the water will accumulate until, by its own pressure, it is brought to the surface through artificial boring—the artesian well—or it may accumulate in the reservoir until it tops it, overflows, and finds an outlet in some ravine or upon some mountain side. In this passage downward the water undergoes many important changes; organic matter is reduced

and destroyed, while mineral matters, and, under pressure, certain gases, are dissolved. The character and temperature of the resulting water will thus depend upon the character of the soil and the depth to which it has penetrated. In soils rich in soluble mineral salts, mineral waters will result, or when the soluble salts are absent, we will obtain an ordinary artesian or spring water, varying in temperature but generally pure—at least, free from contamination by specific germs. The location of the artesian well is, however, of considerable importance, and before driving such a well the advice of one versed in the geology of the district should be asked. The source of the water-supply is dependent upon the geological structure of the district, and is rarely, if ever, coincident with the location of the well-head.

The following conclusions may be stated: In public water supplies, often necessarily dependent upon more or less contaminated sources, we must rely largely upon the means of purification adopted by the municipal authorities. Efforts at household purification of the water are apt to be futile and are not to be relied upon. Each citizen should be made to realize the facts of the case, and all should unite in an effort to hammer reason into the municipal brain. In suburban and country districts each householder should study the question from his own standpoint. Rain water properly collected, filtered and stored is one solution of the problem; a closed well, properly located and attended, is another, while the artesian well is, perhaps, the best of all. In case the latter be adopted, there is no reason why several families should not unite, and thus secure a division of the expense which, for a properly-driven well, is by no means light. Whether the well be dug or driven, the location should be decided upon only after inspection by an expert, and with due regard to the geological as well as surface conditions.

Household purification of water, as we have already said, is not often a satisfactory guard, but various simple operations may be indulged in with profit whereby the water may be much improved in quality. Indeed, in the present absence of efficient municipal control these operations are essential to our health.

Water carrying considerable sediment should be passed

through and drawn from a settling-tank, when the grosser particles will be deposited. Finer suspended matter may be removed by the addition to the water in the tank of a small amount of alum. Iron from the pipes will separate on exposure of the water to the air, and may then be removed by decantation or by any simple filter. A hard water may be softened by adding thereto a small amount of fresh lime, whereby the lime already in solution will be precipitated. Should a suspicion of organic contamination exist, the water should be boiled for a moment or so, cooled and filtered. Should the water taste "flat" after this operation, the normal taste may be restored by shaking the water with air. When ice is used for cooling, it is hardly necessary to add that it should not be placed in the water, but surrounding the bottles containing the latter.

It may be a matter of surprise to some that I do not mention any of the more elaborate methods of purification now so loudly advocated. My experience and observation are that while these more elaborate methods are efficient so long as they receive constant attention, they are apt to fail just at a critical time; that so long as their use continues to be a novelty, all will go well; but just as soon as familiarity has given birth to carelessness, they but add a new element of danger.

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#### A PLEA FOR MORE CAREFUL ATTENTION IN "POST-PARTUM" CONDITIONS.

BY W. F. EDMUNDSON, M.D., PITTSBURG, PA.

(Read before the Homeopathic Medical Society of the State of Pennsylvania.)

How often do our patients in giving a history of their case date its commencement from this or that confinement; and this oft-repeated story has raised in my mind the query, why is it thus? and how can it best be overcome?

I think the fault often lies in the poor attention we give our cases during the puerperium. We are careless in our attention, do not look enough after the details of the case, spending neither the time, care, nor thought on these conditions that their importance demands.

Many physicians do not even make an examination of the perinæum to see whether it is ruptured or not, and for the sake of a little time subject the patient to drag out a miserable existence, or else undergo an operation at some future period which might have been avoided by a careful operation at once. I say a careful operation, for very much of the success in these cases depends upon the thorough and careful manner in which the parts are brought together. They should be looked after closely and kept as cleanly as it is possible under the circumstances. We often hear physicians say they have very poor success in these cases, and so had I until I began to give them more attention, both in operating and in the after care, and now it is the exception and not the rule to have a failure.

If the parts fail to unite we should so inform our patient, and tell her it will be necessary for her at some time in the near future to undergo another operation for the repair of the perinæum. We should also caution her against any violent exercise, viz., lifting of heavy weights, too hurried passing up or down stairs; in fact, the doing of anything that would put unnecessary strain upon the already weakened uterine supports. After the parts have healed and the lochial discharge ceases, we should make a careful examination of the parts to see if everything is in good shape. It may be necessary to snip off little irregularities, thus removing what in many cases may be a constant source of irritation. Also examine the neck of the womb to ascertain if there is a laceration, if so, whether it is enough to cause serious trouble, and in such a case we should request an early operation for its repair.

While perhaps the injury to the health of the patient in this particular lesion has been overdrawn, yet I am convinced from my own experience that it frequently gives rise to many distressing symptoms; and many times has a very important bearing upon the comfort of the patient during the menstrual nisus; and further along in life, especially in the climacteric period, is often productive of very severe and continuous uterine haemorrhages; at least I have seen them time and again cease after the repair of this lesion. While not always successful, yet we should bear it in mind in the treatment of these often intractable cases.

If all the ills of which we read and hear so much are re-

lieved and cured by an operation upon the rectum and anus, why may not also an injury to this, one of the most delicate and susceptible of all the orifices of the body, be a fruitful source of disturbed nutrition and nervous troubles?

The patient should endeavor to pass water at least not a longer time than three hours after the completion of labor; and if this is looked after promptly, the use of the catheter and consequent handling of the parts is avoided. If there is no condition present, such as tendency to haemorrhage, or extreme prostration, or rupture of the perinæum, my plan is to have them slip off the bed on to a commode or a vessel raised high enough from the floor to sit comfortably upon, and believe it preferable to the use of the bed-pan, and far more so than the use of the ordinary vessel in the bed, as we avoid in the former the over-exertion necessary in the latter, and also promote the discharge of all retained clots in the vagina and uterus. Since adopting this plan, have had to use the catheter less frequently.

I also have them, no condition present contraindicating, occasionally lie upon the abdomen for a short time, thus procuring free drainage for all discharges.

In cases where there is a rise of temperature, which I have reason to suspect is due to retained secretions, clots or shreds of membrane, I do not hesitate to open up the womb under proper antiseptic conditions and clean it out thoroughly, and have been gratified in such cases by seeing the temperature drop almost immediately.

In a recent case under the care of my colleague, Dr. G. B. Moreland—miscarriage at the third month—on the fifth day the patient had a violent chill; temperature, when seen, 106° F. Upon inserting the speculum, the mouth of the womb was found closed and the neck slightly bent; and upon opening up the canal a dark grumous, gluey-looking fluid was exuded. The uterus was thoroughly cleansed, but nothing was found in the fundus except some fresh blood. In one-half hour the temperature had fallen to 102° F., and in six hours to 99° F., with a rise the following evening to 102° F., and normal the following morning. In a few days the patient was out of bed and feeling perfectly well.

Great care should be exercised in the handling of these

cases. Nails should be pared very short, arms, hands and instruments should be rendered perfectly aseptic, and the same care should be exercised afterwards so as to avoid carrying the infection to other patients.

I feel perfectly satisfied that had I known of and pursued this practice in the earlier years of my professional life, it would have saved my patients many days and nights of suffering and myself many hours of anxiety and worry.

Erosions and fissures are present in some cases and there may be coexisting œdema of one or both labia minora, and at times I have seen a species of necrotic patch, of greater or less extent, situated on the inside of the œdematous labia, which patch separates in three or four days, giving place to an open wound which requires from ten to fifteen days in which to heal. A slight and continuous fever, for which we often discover no other cause, may be produced by any or all of these lesions, and the temperature remain elevated until the parts are repaired. A knowledge of the origin of a rise in temperature, that otherwise could not be accounted for, may be gained by a careful inspection of the vulva and vagina.

If it should be necessary to use the catheter during the puerperium it should always be a perfectly clean one, preferably one that has never been used before. It should always be passed by sight and not by touch, and prior to its use the vestibule should be thoroughly cleansed ; otherwise the point of the catheter may carry with it some of the lochial discharge, thus causing cystitis and urethritis.

During pregnancy the uterus is modified in form, volume, consistency, situation, direction, and structure, and these must retrograde during the phenomena of involution, in order that it may again return to its normal condition. Involution therefore should receive our most careful attention. After the expulsion of the placenta we have in normal cases both retraction and contraction going on at the same time, and right here would say, that I prefer "Crede's Method" of expansion of the placenta to that of traction upon the cord, practiced as he describes. First because it is in accordance with nature's method *vis a tergo* not *vis a fronte*. Second in those cases where there are morbid adhesions between placental surfaces and that of the walls of the uterus—we avoid the possibility of inversion of the uterus

and also have less probability of shreds of membrane and placenta remain behind. Third, we obtain that great desideratum, namely, a perfectly empty and clean uterus. Fourth, because it can be done without any handling of the parts, which, unless necessity requires should always be avoided. One point, and to my mind a very important one is, never allow the placenta and its membranes to be destroyed until you have carefully examined them.

Failure in the expression of the placenta by Crede's Method I believe to be due to the following reason, viz.: by not following out closely the method as described by Crede; in other words performing it in a careless and imperfect manner; also in too hasty efforts being made to express the placenta—fifteen to thirty minutes, preferably the latter, should have elapsed since the end of second stage of labor.

The uterus should be examined carefully at each visit as to its size, location, etc., and we should endeavor by all the means in our power to remove all conditions which will retard or hinder the process of involution. The length of time necessary for its completion cannot be laid down with exactness—cases varying from six weeks in some to three months or more in others.

If the patient has, previous to conception, been affected with any weakness or displacement of the uterus, the time for involution will be longer and much less likely to be as complete. As to the length of time the patient should be kept in bed, we should be guided by this process of involution, and when circumstances are such as to permit it, should be at least two weeks and preferably three; and she should not have full liberty for at least six weeks. It should be prolonged as long as possible, and should be absolute for the first six days. At the end of the second or third week she may be allowed to lie on a sofa or reclining-chair. Walking should be prohibited until the end of the fourth week; at the end of the fifth she may resume, if necessary, her household duties; at the end of the sixth, everything being in good condition, the patient may be allowed to walk out; and this I prefer to the carriage, and decidedly to the street-car.

In many cases at this period—namely, the end of the sixth week—the menstrual nisus will return. The patient, in such a case, should be made to return to bed, or at least to a reclining position for two or three days.

Convinced, as we are, of the slowness with which involution occurs, and its influence in the production of uterine diseases, we believe it right to insist upon prolonged rest after delivery, and the longer their customary duties are abstained from, the more they assist perfect involution, and therefore the more likely to possess perfect health.

Retractility and contractility alone would not suffice to cause diminution in the size of the uterus, if to these were not added the process of fatty degeneration, which causes the disappearance of certain elements and their replacement by new elements, and also causes diminution in size of other elements acquired during pregnancy. In one case there is total destruction of old elements and an entire new formation; in others there is not total destruction, but simple resorption of part and return to the normal without new development. We have, as a product of involution, excreted from the uterus a number of elements which together are known as the lochia. The lochia last usually for about six weeks, gradually changing in character, and finally disappearing entirely. The odor of the lochia is stale, not very pronounced, and fetor is a grave indication that it should receive our most careful and prompt attention, since it always points to deep lesions of the genital tract. This also applies to acute suppression or sudden disappearance of the lochia. If this discharge is the product of involution, then we know that its suppression is an indication of the temporary arrest of the process, and since the first phenomenon which accompanies puerperal pathology is the arrest of involution, the importance of the regular and normal flow of the discharge is apparent.

As to the use of the douche, it is our practice in the normal puerperium never to use them, for the simple reason that they are useless, and believe that women will pass through exactly as normal puerperium without them. This will apply more forcibly in private practice. The greatest objection to the use of the douche as a routine measure is that it may be a source of infection, especially if the nurse be careless, or where, as in many cases, the patient is dependent upon the kindly offices of a friend or neighbor. The better plan is never to touch the vagina or parts with finger or nozzle during the puerperium unless conditions call for it and the chief symptom is fetid lochia.

In cases of instrumental interferences or the birth of a foetal child, the vagina, and in some cases the uterus, should be washed out thoroughly immediately after the expression of the placenta. We would much prefer for the first washing corrosive sublimate, 1 to 4000; but if frequent irrigation is called for, remembering the possibility of poisoning from this substance, would use creolin, carbolic acid or clean boiled water.

The breasts, and especially the nipples, should be carefully watched. The child should be put to the breast three or four hours after delivery. The patient is then sufficiently rested, and we further obtain the earlier action of the breast or nursing of the child on the uterus, insuring firmer uterine contractions. The nursing period should be regulated from the beginning, the nipples should be carefully washed each time the child is applied to the breast, and at once after its removal. Pure water answers as well as anything, though if they are tender, a lotion of calendula or arnica, or the compound tincture of bezoin will be better. It is not alone sufficient to wash the nipples, but the child's mouth as well should be washed before applying it to the breast. Thus we assist in the prevention of fissures and erosions for the mother and aphthous conditions of the mouth in the child.

The "lying-in" room should be large, light, and airy. Everything about the bed and patient should be kept scrupulously clean. All soiled napkins and linen should be removed from the room at once. The patient should have perfect rest both in body and mind, visitors for the first eight or ten days not being permitted. Keep temperature of room at from 68° to 72°. In winter have a fire night and day. When the graver ailments to which women in the puerperal state are liable arise, the physician is successful indeed who always is able to combat them and restore his patient to health, yet he is far more perfect and successful who so watches, cares for, and guards those under his charge that such conditions never arise.

Is it too much to expect, is it too much to ask for, that in the near future the art of obstetrics will have reached such a stage of perfection, that he who essays the rôle of obstetrician, will be as careful in all the detail and technique in his preparation for the "lying-in period" and the care and attention of his patient in all post-partum conditions, as is the most successful gynaecologist?

## DIETETICS OF TUBERCULOSIS.

BY WM. W. VAN BAUN, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania, Sep. 19, 1895.)

TUBERCULOSIS is an infectious disease, pursuing an acute or chronic course, characterized by either local or widespread lesions, affecting any tissue or organ of the body. Investigators, at present, entertain the idea that the bacillus tuberculosis elaborates from the soil in which it grows a poisonous substance or toxine, which exerts an irritant effect upon the surrounding tissues, and is eventually absorbed into the circulation with the result that nutrition is deranged or modified, giving rise to fever and increased tissue waste, with more or less rapid emaciation.

Poor digestion is a common factor in all forms of tuberculosis; a combination of circumstances constantly leading up to and maintaining the condition. Whenever there is an exacerbation of the symptoms attendant upon the tuberculosis, wherever the location may be, pyrexia is always present, and is, in itself, one of the most prominent disturbing elements of the digestive system. Of equal importance is the impoverished condition of the blood, affecting the quality and quantity of the digestive fluids. In the pulmonary type of tuberculosis, the oftentimes profuse,ropy, tenacious, muco-purulent expectoration, is a source of constant danger to good digestion; the adherent mucus is detached by the food coming in contact with the upper walls of the alimentary tract, and is carried into the stomach, or, the patient raises the expectoration part way, freeing the respiratory tract, but incautiously swallows the specific sputa into the stomach, which, in many instances, gives rise to gastric and intestinal catarrh; or, it may even be the focus of new centres of infection, through the tubercle bacillus causing ulceration of the mucous membrane, thus further impairing the functions of digestion and absorption.

Proper nutrition is one of the most important factors in the treatment of tuberculous cases, and correct dietetics plays no small part in prophylactic, curative, or sustaining treatment.

The patients must receive ample food for their bodily needs, and, in the selection of a menu, the individual's digestive idiosyncrasies or peculiarities must be considered, and weighed well in the balance. Hard-and-fast rules are of little service, as it is often necessary to indulge the whims of patients, and not force them to too rigid a dietary.

Malnutrition is to be particularly feared and avoided; if persistent, it frequently causes a latent tuberculosis to burst out with destructive violence, robbing the patient of energy and vitality, and starting a tissue waste which, unless checked and held in abeyance, soon results fatally. Above everything, a good, nourishing, easily-digested diet, is what is demanded. If patients have not command of a good food supply to maintain their nutrition and strength, all things else will surely fail. Naturally, then, dietetics becomes a question of first importance; and, between good climate and poor food, and severe weather and excellent nutriment, the latter is always to be selected.

With a good appetite and easy digestion, a good liberal diet, even to forced feeding, is desirable; but, with these failing, every effort must be made to stimulate them to the point of successful alimentation. Tubercular appetites are so often poor and capricious, that they will severely tax the resources of the most expert to supply the weakened system with sufficient nutriment to maintain the standard necessary for successful results.

In supplying these patients with diet-lists, I find it of advantage to arrange as long a list as possible of what may be taken at any and all times; secondly, a list of what can be taken occasionally with impunity; and thirdly, a list of what must be avoided. This gives them a sense of freedom of choice that is beneficial.

There is the greatest diversity existing in the power of assimilation in tuberculous patients. I have met whimsical patients, especially in adolescence and of the fairer sex, who crave most absurd things and refuse what is wholesome and sustaining. Here, judicious indulgence, combined with persuasion and tact of a high order, must prevail if successful nutrition is to be obtained.

The *diet* of tuberculosis should principally consist of animal

foods in the following order: *milk, beef, fats and oils.* For some reason not sufficiently accounted for by catarrhal conditions of the stomach and intestines, starches and sugars are difficult of assimilation. In such case malt, which is an excellent tonic, will be found to aid materially the assimilation of farinaceous foods.

In ordinary cases, with fair appetite and digestion, the plan productive of the best results is the alternate use of moderate meals of solid food, with servings of liquid preparations, giving six to seven feedings daily when the patient is not fatigued. This latter is important, for rest holds a marked relationship to digestion. It is advisable to have the patient lie down and rest or sleep a half to three-quarters of an hour after each meal of solid food. In this kind of feeding, to avoid the sense of repletion or fulness, it is an excellent plan to allow eight hours for sleep and then to serve the "solid" meals at regular intervals, giving the liquid nourishment one hour later. This allows three to four hours for the completion of digestion before the next solid meal. If sleep is poor, a more even division can be made of the twenty-four hours, or a liquid lunch can be served with advantage in the middle of the sleeping hours. This method is used with caution, and the amount of food and nourishment is increased as rapidly as it can be borne with safety.

I have used this system in hospital and private practice, even where the evening exacerbations of temperature have varied from  $102^{\circ}$  to  $104^{\circ}$ , with marked benefit, although, as a rule, in such cases it is found that digestion of the heavy or hearty meals is best when the temperature is the lowest. During the period of high temperature in such individuals, milk, treated with Vichy, or koumyss, is much more serviceable. Patients must avoid eating more than they can easily digest, and frequent small meals will reduce the likelihood of overworking the stomach to a minimum.

In cases of feeble digestion it is best to use only one article of food at a time, and usually a liquid preparation is of the greatest service. Of all the articles at our command, *milk* is the most serviceable, provided the patient has not a distaste for and can assimilate the same. Milk is usually taken without annoyance. I use it plain, with a pinch of salt, if agreeable to

the individual palate, or I have it reduced with an equal part of Vichy; this latter preparation will often soothe the throat and allay the cough. As a change, or where milk is not tolerated, koumyss, prepared as follows, is usually well borne: Take an ordinary beer-bottle with shifting cork; put into it one pint of milk, one-sixth of a cake of Fleischmann's yeast, or one tablespoonful of fresh lager-beer yeast (brewers'), one-half tablespoonful of white sugar reduced to syrup; shake well, and allow to stand in refrigerator two or three days, when it may be used. If laid on its side it will keep indefinitely. This preparation is well borne, and from four to six pints daily frequently relieves most annoying gastric symptoms and improves the patient rapidly. Peptonized milk is not acceptable to the majority of patients.

When the pressure of food in the stomach excites cough and induces frequent vomiting, especially if there is gastric catarrh associated with nausea, vomiting and spasmodic coughing, most excellent results are obtained by daily stomach irrigation and artificial feeding, with or without predigested food, through the soft rubber stomach-tube.

*Meats*, in ordinary cases, are available in any shape, and are acceptable to most patients. In fact, some do exceptionally well on immense quantities of beef, particularly if they live much in the open air. The French lay great stress on the nutritive value of meats. Raw beef does not possess any value over rare and underdone meats. The scraping or shredding process has an advantage in that it better prepares flesh for the action of gastric juice. Freshly squeezed broiled beef-juice, served warm but without boiling, is the very best artificial preparation of beef known, and the rapid improvement in the patient will be the best evidence of its advantage.

*Eggs*, as a rule, are of little use in dyspepsia or gastric catarrh; if they are well borne they are of service, and may be used in any style. At times the white or albumin of the egg can be taken when the yolk is indigestible. In laryngeal cases I have had patients suck raw eggs, with amelioration of their throat symptoms.

*Fats and oils*, while now being called to account for too great valuation, still have a strong claim for recognition. Cream, butter, olive oil and cod-liver oil all furnish preparations which

are of utility, provided the individual's power of digestion is equal to the task; they are even allowable in diarrhoeic conditions if the intestines absorb them and oil-globules are not present in the evacuations.

The cereals are of more or less use in tubercular conditions, excepting in tuberculosis of the alimentary canal. When used, if milk and sugar dressing is not digestible, an acid one, like lemon-juice, will overcome the difficulty.

*Fruits* are well borne in most cases and are nutritious. Apples (cooked) are beneficial, and grapes have received much attention. They are used in large quantities, with the idea that they have a curative value in pulmonary tuberculosis. Lebert, in his grape cure, commences with half a pound of grapes at 7 A.M. and 5 P.M. daily; after a short time, if they are well borne, an extra half-pound are ordered to be taken at 11 A.M. This amount is gradually increased to one pound three times daily, the patient being directed to rinse the mouth after each grape-meal with a little soda and water, the general diet being light and unstimulating. The grape cure is practiced extensively at Meran, Montreau and elsewhere in grape Europe during September and October. I have considerably more faith in Lebert's milk-cure than in his grape regimen; for aside from the fact that the climate and sanitary surroundings of these grape-cure centres are perfect, and that the "life" of the cure is such as to induce patients to live constantly in the open air, and to take large quantities of easily-digested food, there is nothing in it of value.

*Alcohol*, on general principles, is to be avoided; it is frequently positively hurtful, and patients who have a fair appetite and are improving in strength have no use for it and should not take it. When it is needed as a food, malt liquors will be found to improve the appetite and increase the weight. When the patient is run down and is anæmic, beer, stout, porter or claret and Burgundy are called for, while the Hungarian wines, like Tokay, are especially useful, if the state of the finances will permit. Sweet wines are productive of dyspepsia. Advanced cases show great tolerance for alcohol, and occasionally marked and continuous improvement follows the daily use of large quantities of whiskey. As hectic advances, less food and more stimulant is demanded, and from four to six or eight

ounces of whiskey can be taken daily with advantage. It is to be remembered that the alcoholic tubercular patient is an easy victim.

Loomis used as a guide for discontinuance, if the exhibition of alcohol increases the temperature and the pulse-rate, and is followed by greater weakness, it is doing harm. Goodno speaks of the risk attending the alcoholic treatment as too great to allow of its recommendation except in carefully-selected cases.

*Suralimentation*, or force-feeding, springs from the idea that tuberculous patients need much more food than natural, to counterbalance rapid tissue-waste. The appetite cannot be considered to properly indicate the real strength of the digestive organs, and forced feeding is instituted. This may be done by means of the œsophageal tube, or without, if the patient is willing to eat.

Debole claims that a patient who has no appetite, or who has a decided disgust for all food, will digest perfectly a large meal introduced by the stomach-tube, and will, at the end of a certain time, regain the appetite. This method is not often necessary, and the possibility of over-feeding must be borne in mind.

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**THE MEDICINAL TREATMENT OF OVARIAN CYSTS.**—Dr. Alfred C. Pope recalls the tendency of *Apis* to excite collection of fluids in serous sacs, together with its very marked power to give rise to irritation of the ovaries: and mentions several instances of its successful use in ovarian cysts. In a very interesting paper read at the British Homœopathic Society last March by Dr. Burford, he carefully describes the various forms of ovarian tumor met with in practice, and illustrating his point by the details of a case successfully treated, expressed the hope that cases of par-ovarian cyst and unilocular cyst might be found amenable to medicinal therapeutics. This thesis was further illustrated by Mr. Pincott, of Tunbridge Wells, who read the report of another successfully treated case of unilocular cyst. In both instances the medicine used was the *bromide of potassium* given in ten-grain doses. To what extent either *Apis* or the *bromide* has been influential in the treatment of ovarian cyst, and how far the result may have been due to other causes it, of course, is impossible to say. But it certainly seems that while we have some reason to suppose that *Apis virus* has a degree of homœopathic relation to this form of ovarian disease, there is none pointing to the *bromide* having any. Dr. T. F. Allen in his *Handbook of Materia Medica and Therapeutics*, mentions in the clinical notes following the symptoms noted on the sexual organs the fact that it has been used in ovarian dropsy, but none of the symptoms recorded either in that book or in the *Cyclopaedia of Drug Pathogenesis* would lead one to suppose that it was homœopathic. On the same occasion both Dr. Burford and Dr. Neathy stated that they had persistently tried *Apis virus* without effect.

In cases of par-ovarian cyst or of unilocular ovarian cyst before resorting to operations, unless there are circumstances which demand the immediate removal of the tumor, and in all where tapping is primarily resorted to, *Apis* or *bromide of potassium* should be resorted to. Dr. Pope's preference would still be for *Apis*, of which he would give five drops of the mother tincture three times day, carefully watching for the production of drug symptoms, which will probably be noted first in the mouth and throat.—*Monthly Hom. Review*, October 1, 1895.

## EDITORIAL.

### CONSCIENCE-BUILDING.

The laws of conscience, which we pretend to be derived from nature, proceed from custom.—MONTAIGNE.

In pursuing the train of thought suggested towards the end of our remarks on “Brain-Building” in the last number of this journal, we would wish to indicate the application of the same experimental facts in the moral sphere. Our oft-reiterated belief that in the advancement of the study of sociology, and more particularly criminology, the physician is called upon to take a prominent and influential part, will be sufficient excuse for the introduction into a medical journal of a subject which might, at first sight, seem to belong rather to morals than to medicine.

While not denying the existence within us of a principle, an Ego, apart from the material of which the body is composed, we must acknowledge that its only knowledge of itself and of the external world is derived through the material sense-organs, and the recognition of impressions made upon them, and through them upon the brain. Molecular changes in the brain, such as we saw attend the reception of percepts derived through the senses, are just as invariably attendant upon the reception or arranging of moral concepts. Every species of mental activity produces definite structural changes in certain brain cells, and these remain more or less permanent, according to the frequency with which the stimulus has been repeated.

In the case of conscience, it is not so much the metabolism of the individual cell which comes into play as the constant and habitual development of certain lines of connecting associations.

Conscience, although usually classed with the moral manifestations, is undoubtedly originally a purely mental condition. Each act of conscience is an act of judgment by which the agreement or disagreement of a certain course with some pre-conceived standard is affirmed. The standard according to which the moral worth of an action is judged, we maintain, has been built up gradually by the habitual connection of cer-

tain percept-memories with certain concept-memories. We use this word to indicate abstract qualities, as good, pleasant, useful, etc., and their opposites, derived from a conscious recognition of the mode of reaction of the cell to its environment. We see, therefore, that the quality of a percept or of a percept-memory must and will depend upon the environment, and herein we recognize the simplest explanation of the great variations found in the so-called dictates of conscience.

In tracing the ethical development of our race we cannot but recognize the fact that there never has existed a universal rule of right, acknowledged to be such by all men. We suddenly find in the history of man a certain something, which, by moralists, has been termed conscience, and which has been found to underlie either laws or precepts, according as it concerned the relations of man to man or to a divinity, and according as they were promulgated by the state or enjoined by the church.

If we examine impartially this so-called conscience or its dictates, we will find that it was merely a crystallized judgment as to the utility of an action. This utility, in the first place, was limited to avoiding conflict between man and man and between man and a deity, and then by a gradual enlargement of the concept it was made to include more the positive idea of active benefit to man and the state and to deity.

We can trace the existence of the idea of benefit to the deity, even among the Children of Israel, in the denunciations hurled against it in the prophetic books of the Old Testament. In the present day we find it still existing in the popular notion of works of supererogation, as found in the Roman Catholic Church. A higher plane has been established in the desire to use certain actions as a means of becoming pleasing to the deity, and the climax has been reached in the deification of the idea of Duty apart from precept.

We find therefore, that there is no intrinsic morality residing in any action, but it is called good or bad according to its usefulness within its own environment. Many things condemned by the modern conscience were deemed praiseworthy by the conscience of past ages, and *vice versa*. Not only do the present and past conscience differ, but the public conscience of one country differs from that of another even at the present day. Applying these psychico-physiological principles to the problems

of sociology, we will see that conscience-building according to Prof. Gates's theory, offers a more hopeful solution to many than all the suggestions of penology. Let the beginnings of conscience-building be made in the kindergarten, where it has always seemed to us this point has been neglected. Besides endeavoring to develop the cells by presenting percepts, let us develop the associations which connect them with abstract concepts of good, beautiful, useful, or their opposites. Let the proper connections and associations be so frequently repeated that they will always offer the direction of least resistance in the future mentation of the individual. By proper connections and associations we mean those which are most in accordance with the present environment, not with an environment which is only a matter of tradition or of historical record. If we do not always get results which will tally with the arbitrary dicta of the moralist, we will at least have such as tend to adapt the individual to his present sphere, and which will less readily be confused by the indefinite claims of abstract duty.

It will easily be seen how from this standpoint questions may be answered as to capital punishment, divorce, the responsibility of the insane and drunkards, and their liability to punishment, about which there are such various opinions.

The key-note to the whole can be made to lie in the amplification of the old saw, Honesty is the best Policy.

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#### THE RETORT COURTEOUS.

In the "Editorial Comments" of our esteemed contemporary, the *Medical News*, of November 30th, we read that one of his esteemed contemporaries had remarked that "Germany had never ventured to erect a statue to Hahnemann." This gives our esteemed contemporary an opportunity to show his acquaintance with the topography of Leipsic, his knowledge of the German language, and his well-known spleen against Homœopathy. The first he does by calling the place where stands the statue of Hahnemann "an inconspicuous corner of Leipsic." It is fortunately conspicuous enough to find mention in all guide-books and encyclopædias. The second he does by quoting a very neat German conundrum, and its punning answer, without, however, translating either. Why he does not translate them we are at a loss to understand, unless he

thinks *Omne ignatum pro magnifice*, and trusts thereby to impress his hearers. We will leave our quotation untranslated, perhaps for the same reason,—who knows? The third he does by asserting that in the effort to raise money for a statue to Hahnemann here in America, “one aspect of the matter is not sufficiently emphasized. Both the monument and the money-raising are made a standing advertisement. The honor or principle involved is purely figurative or assumed.”

We wonder that the proprietors of our esteemed contemporary allow him to be so persistent in his attacks upon a system which numbers among its adherents so many possible patrons of their publications. We have always heard that homœopathic physicians are by far the most liberal book-buyers.

Personally we should be sorry to see the anti-homœopathic utterances of our esteemed contemporary suppressed. When we have not at hand our *Puck* or *Judge* or some other avowedly comic weekly, we gladly turn to the pages of the *Medical News*, where we find in the choreic attacks on Homœopathy a never failing source of innocent, unstimulating amusement.

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#### NEW YEAR.

“Praise from a friend, or censure from a foe,  
Are lost on hearers that our merits know.”—POPE.

ANOTHER year has passed over the HAHNEMANNIAN MONTHLY and the rest of mankind, and we find ourselves standing at an arbitrary, invisible chalk-line, ready to start on a new portion of our race between two eternities. The We, Us & Co., yclept the HAHNEMANNIAN MONTHLY, has worked while it was called to-day, and its work has been sent forth never to be recalled. What has been done has been done for ever. What harm or good has resulted is now beyond control. It is a solemn thought, and will no doubt resound from many a pulpit at this season. As our sanctum is no church, we will preach you no sermon, but only set forth our greetings and best wishes for—what?

Professor Eulenspiegel, to whom we mentioned our intention, delivered himself somewhat in this wise: “Whom will you greet, and what wishes will best show your good-will? Is it the few readers of your editorials, and the many readers of the

journal? Is it the host of co-laborers catalogued in your long December Index? All these? So be it; but who are they, and what do they want that you can wish them? Are they the M.D.'s with whom you shake hands; the men whom you meet on the streets and at your societies and clubs, the ones with whose faces you are familiar, and whom you address, 'fraternally yours?' Ah, my friend, those to whom you should address your greetings and wishes are none of these, they are but their *simulacres*, their images. The inside of them you know not, with all your anatomy, and your greetings and wishes will slip as water from a goose's back. Shall your ideas of happiness or prosperity be the standard of your wishes to them? Will you, at zero temperature, wish warmer weather to a fever patient, or long life to one sighing for death? The heart knoweth its own bitterness. Each man carries his own world under his hat, and you and I are perhaps not 'in it.'

"Greet all as you would the unknown loiterers at railroad stations as your train flies by, and wish them all the fulfillment of their own heart's secret desires.

"So only will you testify your good-will, and they shall rise up and call you blessed."

Although we strongly suspect a little anticipatory mental indigestion in the good professor, his thought is not altogether an irrelevant one, and we wish to all a new year, made happy by a realization of their own wishes.

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#### A TEST FOR INCIPIENT DIABETES.

"PROF. V. NOORDEN says *he has discovered a new means of diagnosing diabetes in its very earliest stage, or even a hereditary tendency thereto.* He gives the patient 100 grains of grape sugar, which in the normal subject, has no effect, but in the incipient diabetic produces glycosuria. If this prove correct, it will be most useful in gaining for the diabetic the earliest possible treatment.—*Medical Record.*"

The italics are ours. Prof. V. Noorden and the *Medical Record* are mistaken. This is not a *new test of "diagnosing diabetes."* It is virtually Prof. Clifford Mitchell's method of diagnosing diabetes, and was clearly given in his articles on "Champagne and Diabetes," appearing in the HAHNEMANNIAN MONTHLY for May and August, 1892, pages 327 and 565.

## GLEANINGS.

### GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D., AND FRANK H. PRITCHARD, M.D.

**REMEDIES IN HEART DISEASE.**—Prof. Thomas R. Fraser, of Edinburgh, whose name is so well known in connection with the investigation of the properties and uses of strophanthus, has a paper in the *Edinburgh Medical Journal* (April, 1895), on the “Remedies Employed in Cardiac Affections and their Indications.” He considers that strophanthus occupies the first place in contractile power, and considers the rapidity of its action to be due to the fact that its active principle is soluble in less than its own weight of water. Perfusion experiments have shown that extract of strophanthus is 8 times as active as adonidin, scillitoxin and erytrophlein, 20 times as active as helleborin, 30 as convallamarin, 300 to 3000 as digitalin, and 30,000 as caffein. The simple indication for the use of cardiac tonics is, in Prof. Fraser’s opinion, cardiac insufficiency, and that form of tonic is best, in individual cases, which the practitioner has used most, and with the action of which he is best acquainted. The sound sense of this advice is self-evident; but there are facts, clinical and physiological, which still cause us to hesitate in accepting without reserve too sweeping generalizations as to the effects and uses of well-known cardiac tonics.

Thus strophanthus in very minute doses has been shown to induce in the frog’s heart a systolic contraction which nothing but the decomposition following death undoes; but in the discussion on the mechanics of the cardiac cycle at the last meeting of the British Medical Association, it transpired that Dr. Berry Haycraft had found that the dead heart of a dog poisoned by strophanthus was in a condition of diastole. Excellent sections demonstrating this fact were shown. Again, comforting as it would be to arrive at the generalization that heart failure was a sufficient indication for the use of heart tonics, there are those who have not been able to bring themselves to regard the digitalis group as equally beneficial in mitral and aortic regurgitant lesions. Prof. Fraser himself regards the better results obtained in mitral regurgitation as compared with mitral obstruction to be due to the relatively small muscular power of the auricle. May it not, however, be in a measure due to the relatively greater difficulty of the diastolic ventricle to aspirate blood through the narrowed auriculo-ventricular opening?—*The Practitioner*, November, 1895.

**A CASE OF GONORRHOEA COMPLICATED BY POLYARTHRTIS, DISTURBANCES OF THE NERVOUS SYSTEM, IRRITIS AND CYCLITIS.**—Dr. Kucharzewski, of Warsaw, describes a case of gonorrhœa where three weeks after contracting the disease rheumatic pains appeared in the wrist- and knee-joints, but unaccompanied by fever, and seemingly keeping pace with the intensity of the urethral affection. In fourteen days the conjunctival and subjunctival bloodvessels became injected, as well as those around the cornea, while the cornea itself remained normal. The pupils, in spite of frequent instillations of a solution of atropine, remained but a little dilated; the iris was normal. Pain in the ciliary body was experienced both spontaneously and on contact. No signs of syphilis nor tuberculosis could be discovered either in his history or objectively.

Nearly four weeks from infection the patient complained of pains in the lumbar region and under the sternum, with formication and pain in the lower extremities. Examination revealed hyperesthesia of the legs and thighs, painfulness of the lumbar vertebrae, increased patellar reflex and foot-clonus. The bladder and rectum were normal; no increase of temperature. As neither tuberculosis nor syphilis were to be made out, either objectively or subjectively, he is inclined to regard this series of affections as of gonorrhœal origin. Ten weeks after infection the patient left the hospital, with augmented reflexes, foot-clonus and slight turbidity of the fundus of the eye.—*Therapeutische Wochenschrift*, No. 17, 1895.

**AN EARLY SIGN OF MEASLES.**—Dr. P. Bolognini claims to have discovered a pathognomonic sign in measles which is even so early as to forerun the eruption for twenty-four to forty-eight hours. To elicit it the little patient is placed upon the back and with the thighs flexed while the examiner, sitting at the child's side, presses the tips of the middle fingers of each hand upon the abdominal wall and towards each other so as to gather up a fold of the wall and to press the parietal layers of the peritoneum together. Then, if the disease be already under way, one will notice a friction fremitus due seemingly to a very mild lesion of the peritoneum a sort of enanthem, which like the eruption upon the mucous membranes, would appear to precede the appearance of the exanthem, upon the skin. In an epidemic of two hundred cases he has been able to confirm this diagnostic sign in the greater number of cases.—*Lo Sperimentale*, No. 16, 1895.

**FUNNEL-SHAPED STENOSIS OF THE PULMONARY ARTERY.**—Dr. Barié has recently observed a woman suffering from Addison's disease who presented an infundibular narrowing of the pulmonary artery. At the necropsy a hard, sclerotic and whitish ring with a limited opening of about five millimetres was found. It was about a centimetre in length, its walls were hard and rough, and it was situated about twenty five millimetres above the pulmonary orifice, which was absolutely normal. All the other cardiac valves were normal; the pulmonary artery was dilated funnel shaped above this stricture.

Clinically, it gave rise to a very intense vibratory systolic fremitus and to a rasping murmur which commenced with the systolic and persisted till the second sound. Beyond a slight palpitation there were no signs of a heart disease. The murmur was best heard at the third left chondro-sternal articulation, and at the apex of the heart; in stenosis at the pulmonary valve itself the murmur will be best audible at the second left intercostal space along the sternum. The disease is very rare, and is most frequently met with in women. It may be due to an endomyocarditis or associated with tuberculosis. It may be confounded with interventricular communication through a communicating septum or even with a mitral lesion on account of the intense murmur being audible near the apex.—*La Semaine Médicale*, No. 37, 1895.

**FALSE CYSTITIS.**—Dr. A. Guépin calls attention to a certain class of patients who have apparently all the signs of cystitis, as frequent micturition, dysuria, pyuria and even increase of vesical tenderness on distension of the bladder with urine, but who still have no cystitis, but a series of reflex vesical symptoms which are dependent upon a distant affection of the urinary tract. These may be renal or ureteral lesions, pericystitis, deep urethral disturbances, pyelonephritis or ureteritis. Diagnosis may be made with the cystoscope, a study of the antecedent history, complete examination of the patient and the ineffectiveness of the usual treatment of cystitis.—*La France Médicale*, No. 31, 1895.

**AUSCULTATORY SIGNS OF MITRAL STENOSIS.**—Dr. Steel, from a study of mitral stenosis in 60 cases, of which 18 were followed by necropsy, has found an accentuation of the first sound at the apex and reduplication of the second sound to be frequent auscultatory signs. A systolic blowing sound at the apex is often observed, though a diastolic murmur is more frequently observed than the characteristic presystolic souffle; the diastolic sound may be noticed in aortic incompetency, and even may be present without a valvular lesion being behind it. The left ventricle he has found larger than has been usually held. A circumscribed redness of the cheeks he has noticed to be pathognomonic in 31 per cent. of the cases. The disease, as a rule, passes through three stages. In the first the auscultatory signs, especially the presystolic murmur, are most pronounced, while there are but slight or no circulatory disturbances. At this period the pulse is regular, of a high tension, or, in short, natural. In the second stage, the disturbances of circulation are more distinct, and the pulse is irregular, of low tension, but it alternates with a more or less tense and strong state. The condition of the pulse is not pathognomonic, for the same state is to be observed in degeneration of the myocardium. Many patients die in this stage. In the third stage, the pulse may again become regular, but it is of low tension. The patient may improve of himself, and go through the first two stages again with a weak and changing pulse. There is no characteristic pulse for this condition.—*Hospitalstidende*, No. 41, 1895.

**PASTEUR'S DISEASE AND DEATH.**—The final and fatal disease of the celebrated French savant, Pasteur, was a chronic nephritis with uræmic attacks. Already in

1868 he was seized by a right-sided hemiplegia as he was about to finish his very exhausting studies on the diseases of silk-worms. He retained a halting gait and decreased mobility of the right hand.—*Ibidem*.

**THE DIET IN CHLOROSIS.**—Prof. Hayem in grave cases of anæmia would put the patient to bed. The diet is of primary importance. A gastric disease always precedes the blood-affection, and, in the majority of the cases, there is a moderate degree of dyspepsia with dilation. Before prescribing any preparation of iron the diet is to be attended to. At first, milk and raw meat, then soft boiled eggs, fish that are not fat, green vegetables in the form of purées, and boiled fruits. Only after four to five weeks does he allow bread to be added. Contrary to Ziems-sen, he first advises treating the stomach before administering iron, for, though a decided improvement will be obtained by immediately giving the remedy, yet no definite recovery will follow in cases of pronounced gastritis. In case of grave gastritis he advises rigid diet, abdominal massage, discontinuance of the corset, and, if necessary, washing out the stomach. He would give the iron before meals and hydrochloric acid half an hour after. Of all the iron preparations he prefers the protosalate, as it greatly shortens the duration of treatment.—*Therapeutic Monatswochenschrift*, No. 17, 1895.—[Pulsatilla is an excellent remedy for the gastric catarrh; after this has yielded then follow with iron.—Eds.].

## GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D. AND H. L. NORTHROP, M.D.

**NEW VIEW OF THE TREATMENT OF VOMITING AFTER CHLOROFORM ANÆSTHESIA.**—Lewin relates his experience with the use of vinegar to prevent vomiting in 174 cases of chloroform anæsthesia. In 125 cases, he says, he has obtained complete success, no vomiting of any kind having been produced. In 49 cases there was vomiting, but it was generally slight, and the rejected material was rather viscous. The method should be very carefully carried out, he says, in order to insure good results. It is known, he remarks, that chloroform is eliminated almost exclusively through the lungs, partly as free chloroform and partly as formic acid and chlorine. It is evident, he says, that the chlorine exercises an irritating action on the larynx and on the trachea, and that this is one of the principal causes of the vomiting. When a cloth saturated with vinegar is held over the nostrils, the chlorine combines with the acetic acid as fast as it is evolved, and forms trichloroacetic acid.

It is known, he continues, that chloroform dehydrates the tissues, and, consequently, after the action of the chloroform has been suspended, it is well to make the patient breathe in air that is as humid as possible. This dehydrating action, says the author, influences also the endothelium of the bloodvessels and causes coagulation of the blood, to which the slackening of the circulatory movement and the feeble activity of the chemico-biological phenomena in the capillaries also contributes. Under such circumstances, acetic acid is a powerful factor in restoring to the blood its normal fluidity, owing to a property that it derives from the water it contains, and to its energetic power of destroying the fibrin. Moreover, acids in general are stimulants of the respiratory tract. The foregoing considerations seem to him sufficient to explain the phenomena without bringing forward a hypothetical action of the vinegar, or of acids in general, on the vomiting centre by the intervention of the vaso-motor nerves.

The following observations were made in cases where this treatment was employed by the author. Immediately after the application of the vinegar the pulse became strong, respiration grew deeper, the face regained a little color and the corneal conjunctiva became bright.

The method of application is as follows: A piece of linen of about the size of a napkin is saturated with vinegar and lightly wrung out. It is then placed on the patient's face, over the mask, which is afterward carefully withdrawn, care being taken not to allow the air to gain access to the face too suddenly, for it ought to pass through the linen cloth before being inhaled. This cloth must be kept on

as long as possible (for three hours at the least), and it is better for the patient if the application is prolonged during the entire day, for occasionally the presence of chloroform in the expired air has been observed for more than two days after the narcosis. If the cloth is removed too soon, nausea will set in. If the linen cloth dries very rapidly, it must be replaced immediately with a fresh one, which is put over the first cloth, before the latter is drawn away, in order to prevent the air from touching the face. It is of the greatest importance to conform to these rules, says Lewin, for failure to observe them has prevented good results from following application of the vinegar.—*Revue de Chirurgie*.

## GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY  
GEO. R. SOUTHWICK, M.D.

**ASAFETIDA IN OBSTETRICAL AND GYNÆCOLOGICAL PRACTICE** — Wahrmann has tried the drug in cases of threatened abortion, and though the miscarriage was not prevented, the loss of blood was very materially diminished, pains in the sacral and hypogastric regions were lessened, and did not appear to any extent till just before the contents of the uterus were discharged. The haemorrhage ceased immediately afterwards. The drug was given in doses of twenty-five or thirty drops daily in enemas of two or three tablespoonfuls of water. He has also used it successfully in pill form for the treatment of habitual abortion. In a woman thirty-five years old who had aborted fourteen times in nine years and had been repeatedly curedtted, the pregnancy continued to its natural termination in a perfectly normal manner under this treatment. He prescribed gummi resine asafetida, 6.0 f. pilul., No. 60; two pills daily, gradually increased to ten pills daily, with gradually diminished doses till labor came on at full term. The remedy had a good effect on migraine, cardialgia, dysmenorrhœa, etc., as well as on the nervous symptoms during pregnancy. Its best effect was shown in habitual obstipation, where it seemed not only to excite the diminished peristaltic movements, but to relieve also the reflex irritation causing the obstipation, such as pelvic inflammation, haemorrhoids, etc.—*Centralblatt für Gynäkologie*, No. 32, 1895.

**A CASE OF UNCONTROLLABLE MENORRHAGIA REQUIRING HYSTERECTOMY TO ARREST THE HÆMORRHAGE**—Switalski.—The patient was 29 years old, and had one child ten years previously. In June, 1894, one week after menstruation, she began to flow without any assignable cause and the flow lasted some days. In July the bleeding returned, was much more severe, and the patient was taken into the hospital. Haemorrhagic endometritis was diagnosed and the uterus curedtted. The period returned very profusely on the 20th of August, and the patient was dismissed from the hospital at her request. She began to menstruate again on the 24th day of September, and the bleeding continued through October in spite of rest in bed, applications of ice, secale cornutum, subcutaneous injections of ergot and the use of tampons.

Everything was unsuccessful; the bleeding continued without intermission, and the patient became more anaemic and weaker from day to day. The bleeding finally ceased in November, and the patient entered the hospital in a very anaemic condition. Careful examination on the 21st of November showed that the lungs, heart, liver, spleen and kidneys were in normal condition. The uterus was ante-flexed, a little enlarged and movable. The adnexa were normal. The examination with the sound showed a normal depth of the uterus and a smooth endometrium. The use of the sound was painless and bloodless. Rest in bed, strong nourishment and ferrum were prescribed. The patient flowed profusely from the 22d to the 24th of November, fluid blood with large clots. Prof. v. Jordan decided to make a digital examination of the uterine cavity, and after a careful dis-infection of the vagina he introduced a strip of iodoform gauze into the cervical canal on the 10th day of December, which was allowed to remain two days. This was repeated on the 12th with the intention of dilating the next day with Hegar's dilators, enough to allow a digital examination; but on the same day the patient had a chill and rise of temperature to 3° C. At the same time she complained of severe pain in the left iliac region. The strips of gauze were removed, the va-

gina and cervix were disinfected, the ice-bag applied and narcotics given. The fever and pains ceased on the third day. Severe pain soon appeared in the right iliac region, and on the 11th day of December a right-sided parametral exudate was diagnosed. The patient began to bleed again on the same day. The haemorrhage could not be arrested by any means. Ice compresses, secale cor., ergotin, hydрастинум hydrochl., digitalis and permanent irrigation with cold water regulated by a thermostat were tried in vain. The anæmia became extreme, the patient somnolent, and the soft, quick pulse with slight rise of temperature towards evening showed that quick and energetic measures would be necessary to save the patient. Total extirpation of the uterus was performed with Richelot's clamps, and the patient slowly recovered. The removed uterus appeared perfectly normal macroscopically, and the microscopical examination of it at the pathological institute by Prof. Browicz showed no cause for the haemorrhage. The only alterations which could be found were slight interstitial alterations in the endometrium (interstitial endometritis), which in no way would explain the hemorrhages. It is well known that severe menorrhagias, and much more rarely metrorrhagias, may occur without any pathological changes of the genitals. They are explained by the so-called haemorrhagic diathesis, as morbus Werlhofii, scorbutus, etc., in infectious diseases, in various cachexias, polysarcia, icterus gravis, Bright's disease, heart and liver diseases. These hemorrhages are very rarely so abundant as in the present case, and there were none of these causes found present. In fact, the cause of the haemorrhage remains unexplainable.—*Centralblatt für Gynäkologie*, No. 33, 1895.

**THE ANATOMY AND THERAPEUTICS OF CARCINOMA OF THE BODY OF THE UTERUS—Hofmeyer.**—Infection of the wound during the operation is a very common cause of recurrence, and the cervix should be carefully stitched together and its canal tightly closed before extirpating the uterus. Adenocarcinoma has a strong tendency to lead to metastases throughout the uterus in the course of the entire genital canal. The vagina should be split open in a hysterectomy, so as to obtain free access to the connective tissue. Comprehensive statistics show that the prognosis of final results of the operations for cancer of the body of the uterus are more favorable than those of the cervix or vaginal portion of the uterus. There may be a late recurrence, but if the patient lives a year without recurrence after an operation for cancer of the body of the uterus, she is likely to remain well. The reason for this more favorable prognosis in these cases is that the rigid walls of the uterus offer more resistance to metastasis through the lymphatics than is found in the cervix.—*Zeitschrift fuer Geburtshuile und Gynakologie*, Bd. xxxii, H. 2, 1895.

**AN EXPLANATION OF KUESTER'S SIGN OF A DERMoid TUMOR—Scheunemann.**—There are not wanting many observers who believe that the mere location of a tumor is not characteristic of a dermoid. Mandelstam reports two cases in which Kuester's sign was present and led to a correct diagnosis. He explains that it is due to the greater weight of a dermoid tumor as compared with an ovarian tumor. If the pedicle is long enough to permit, the dermoid sinks down to the median line toward the linea alba. This is increased with the growth of the tumor and its fatty metamorphosis of the specific detritus within it, so that the tumor is forced forward from its original bed to the median line. Traction on the pedicle is not arrested till the tumor rests on the abdominal wall. We have as the result the typical conditions found on examination—a small tumor, the size of a fist, cystic, median and anterior to the uterus in the small pelvis like an ovarian tumor close behind the symphysis pubis. If the tumor grows and the pedicle stretches, hand in hand with the growth of the tumor, the latter will rise out of the small pelvis, but will always maintain its median position. If the pedicle does not yield and follow the growth of the tumor, a part of the latter will remain in the small pelvis while the bulk of it extends into the abdomen. Exceptions to this type may occur.—*Ibid.*

**THE BACTERIOLOGY OF THE CERVICAL CANAL—Stroganoff.**—The writer made a careful study of the subject, and come to the following conclusions:

1. The cervical canal in both pregnant and non-pregnant women is, as a rule, sterile.
2. The region of the external os separates the portion of the genital canal free from bacteria from that part containing bacteria.
3. The cervical canal slime destroys micro-organisms.—*Centralblatt für Gynäkologie*, No. 38, 1895.

**MONTHLY RETROSPECT  
OF HOMEOPATHIC MATERIA MEDICA AND  
THERAPEUTICS.**

CONDUCTED BY

CLARENCE BARTLETT, M.D.,  
FRANK H. PRITCHARD, M.D., AND F. MORTIMER LAWRENCE, M.D.

**PSEUDO-CHANCRE.**—William S. Gottheil, M.D., states that reinfection syphilis does occur, but the recorded cases that are entirely trustworthy are very few indeed. Analysis shows that most of the alleged cases are open to grave doubt, and that some of them are manifestly errors of diagnosis.

The following lesions may simulate chancre :

- a. Artificial indurations caused by irritants applied to simple lesions.
- b. Nodular lymphangitis, as occur in gonorrhœa.
- c. Scabies, where penile lesions are the rule.
- d. Secondary indurations at the site of the initial lesion (Fournier's pseudo-chancres).
- e. Secondary syphilitic papules or tubercles situated upon the genitals.
- f. Ulcerative gummata of the genitals.
- g. Epitheliomata of the genitals.

Two such cases have recently come under the author's observation. In the first one a non-specific sore was irritated with cauterisants until it exactly resembled a sclerosis, and was so diagnosticated by competent authorities. Nevertheless it healed up under local treatment alone, and until now, two years after date, no secondary symptoms have appeared.

The other case was one of gumma of the penis in a subject in the tertiary stage of syphilis. The lesion resembled an initial one very closely and was at first regarded as such, but a close examination showed the presence of evidences of past specific disease, and this was confirmed by the history. The entire lesion melted away under the iodide of potassium.

Conclusions :

1. There is no characteristic sign and no characteristic combination of signs that enables us to diagnosticate a chancre from the lesion alone.
2. Only the advent of other syphilitic symptoms enables us to form an opinion as to the presence of systemic infection.
3. Almost all the alleged cases of syphilitic reinfection are of doubtful validity and most of them are pseudo-chances belonging to one or other of the above varieties.—*New York Medical Journal*, 1895.

**THE TREATMENT OF INFLUENZA**—According to Dr. Richard Hughes (*Southern Journal of Homœopathy*, July, 1895), in influenza we have a specific fever to treat; and sometimes this and this only. In accordance with the form it assumes we should administer one or another of our well-tried antipyretics—aconite, gelseinum, belladonna or baptisia.

(a) Aconite is less suitable in such a fever than in one resulting from cold; nevertheless, when it is indicated by the symptoms it will do good service, as it does, for instance, in measles. The sthenic character of the pyrexia, the fulness with quickness of pulse, and the presence of thirst, restlessness and distress, are the well-known indications for it, and may be truthfully followed. This only must be said, that it is not to be expected of aconite that it shall act here as it does in a fever from a chill, breaking it up in a few hours. We have a blood-infection to deal with, which will have a certain course; and, as in measles, we must give the remedy persistently for two or three days, awaiting the resolution of the pyrexia—which, however, it is all the while moderating and soothing.

(b) *Gelsemium* takes the place of aconite when the fever is less sthenic and chills mingle freely with the heat ; when the pulse, though it may be full, is less tense and rapid ; when there is little thirst, and when the patient's general condition is one rather of torpor and apathy.

(c) *Belladonna*, standing at the head of our remedies for the infectious fevers, plays its part well here when the symptoms demand it. These include a pulse smaller but even more rapid than that of aconite, and a dry, hot skin ; but they are chiefly to be found in the head and tongue. Dryness of the latter, heat and pain (with flushed face) of the former, call unmistakably for it, and when they are present, we need hardly look farther for our remedy.

(d) *Baptisia*, coming here crowned with its laurels in the "gastric" type of continued fever, just fills the vacant niche when such symptoms characterize the influenzial pyrexia. A gastro-intestinal form of the disorder was noted by the earliest observers, and has recurred in the present epidemic, as may be seen in the article on influenza in the new edition of Duane's *Dictionary of Medicine*. When the tongue is thickly coated, when there is nausea and vomiting, and when the stools tend to be diarrhoeic—especially if also flatid—*baptisia*, already suited to the pyrexia, becomes so to the whole condition, and will change it for the better more rapidly than any other medicine.

Dr. Hughes uses these drugs only in the lowest ( $1x$  and  $2x$ ) dilutions. For the rheumatoid pain of the back, head and limbs, in aconite cases, he has found *bryonia* helpful to the head and *eupatorium perfoliatum* to the back and lower limbs. For the catarrh : When it is simple *coryza*, *euphrasia* if the discharge is bland, and *arsenicum* if it is acrid in the first, fluent stage, and *pulsatilla* after it has become thick and opaque. When it is laryngo-tracheal, *spongia* acts best, with careful individualization of the remedy if the cough is persistent. For bronchitis, *kali bichromicum* in the first stage, and *antimonium tartaricum* later, have given Dr. Hughes good service. In the treatment of the most serious of complications—pneumonia—*bryonia* and *iodine* have little place, while *phosphorus* stands supreme. It should be replaced by *antimonium tartaricum* only when pain, dulness on percussion and bronchial breathing have subsided ; when pulse, respiration and temperature have fallen, but when yet the chest is full of moist sounds and the patient is oppressed and distressed. Finally, for the debility remaining after the acute attack is over, Dr. Hughes finds the great "tonic" to be *phosphorus*.

**THE ACTION OF APIS ON THE URINARY SYSTEM.**—When in cases of bee-poisoning, oedema of some portion of the body has been set up, the secretion of urine becomes scanty. When, on the other hand, the brunt of the poison has been thrown elsewhere, this secretion of urine is considerable. Eliminated through the skin the virus would seem to paralyze the function of the kidneys whereas, when determined towards that organ it stimulates it to increased action.

Dr. Farrington says that " *apis* is especially useful in renal dropsey, whether the result of scarlatina or not. The urine is scanty and highly albuminous and contains casts of the uriniferous tubules. There is a swelling about the eyelids. The surface of the body feels sore and bruised ; in some cases the pain is of a burning character." (*Clinical Therapeutics*.)

On the bladder and urethra its action is much more distinctly marked. The bladder is intolerant of the presence of urine and calls to evacuate it are frequent both day and night. At the same time, the secretion is hot and its passage gives rise to burning. In these symptoms it much resembles *cantharis*, as, indeed, it does in others. It is a mild form of catarrhal cystitis and urethritis in which it is indicated, and especially those which surgeons describe as urethral fever.—*Monthly Hom. Review*, October 1, 1895.

**THE INTESTINAL ACTION OF APIS.**—The gastric symptoms excited by *apis* are apparently purely sympathetic to disturbances produced by it in other parts. On the lower part of the bowel it seems to have a specific action, giving rise to a diarrhoea, with which is associated vomiting of bile and bile-tinctured mucus. The abdomen at the same time is sore, occasionally the pain is severe, and there is a good deal of flatulence. One characteristic of the diarrhoea of *apis* poisoning is that it generally occurs in the morning. The stools are thin and watery, and occasionally bloody, and are followed by much weakness, and even prostration. Some have noticed that this morning diarrhoea is ordinarily present where the ovarian irritation, to which *apis* is homeopathic, exists.—*Monthly Hom. Review*, October 1, 1895.

A PROVING OF BORACIC ACID.—Mr. Dudley Wright records the case of a patient, formerly under his care for advanced prostatic hypertrophy, who was in the habit of daily washing the bladder with nitrate of silver solution and taking occasional doses of boracic acid by the mouth to overcome the alkalinity of the urine. The treatment had been persisted in for fully two years before any ill effects were produced. The patient, a lean, spare man of over sixty years of age, showed marked evidences of a gouty diathesis.

According to his daughter, while on a visit to Yarmouth he commenced taking *boracic acid* as he had frequently taken it before, a teaspoonful dissolved in a tumbler of hot water, taken in three doses during the day. It had a marked effect upon the urine, which became much clearer with a decrease of the thick mucous deposit. The three daily doses were taken on Monday, Tuesday and Wednesday. On Wednesday morning a slight redness appeared on the face and hands and increased during the day. The *boracic acid* was stopped. On Thursday morning the face was a bright red and very much swollen, and there were distinct patches of red on the forehead and above the upper lip. The inflammation extended also to the head and neck, and the hands were swollen, especially the left, and the palm was very red and tender and inclined to itch. The feet and ankles were also swollen and covered with small red spots, more definitely a rash than on other parts. The rash extended up the legs and was extremely irritable. The appearance of both feet and hands was like prickly heat. The physician who was called in said that he had had one similar case—a man who was suffering from cystitis and who was being treated with *boracic acid* and *salol*, but which of the two had caused the condition he could not determine. On Friday and Saturday the symptoms continued much the same. By Sunday the swelling began to subside and the redness to pass off, and in two or three days had quite disappeared from the face. The hand remained longer swollen—perhaps for a week—and then peeling commenced on all the parts which had been affected. By the end of the week, the urine having become very thick again, the doctor recommended that the *boracic acid* should be resumed, but no more than three doses had been taken before the face showed decided signs of swelling and redness again, so no more was taken.

After his return home, thinking that the *boracic acid* he had taken in Yarmouth might not have been quite pure, he took a few doses of the London article. In two or three days all the symptoms of the first attack reappeared. When Mr. Wright saw him after this last attack the skin of face and feet was dry and inclined to peel, as after erysipelas, while the hands were still slightly oedematous and a slight crimson blush of the skin was present.

Mr. Wright does not doubt that *boracic acid* caused the patient's dermatitis, and suggests that the well-known tendency of sea air to excite and aggravate skin affections of an inflammatory nature may account for the sudden appearance of toxic symptoms after so long a period of immunity from ill effects.—*Monthly Hom. Review*, Oct. 1, 1895.

CEDRON IN LEFT-SIDED FACIAL NEURALGIA.—Dr. Wingfield reports the following cases :

CASE I.—A girl, aged twenty, for two weeks had had severe shooting pains on left side of face. They recurred several times daily, lasting for about an hour, and were aggravated by heat and better when she moved about. *Gelsemium 1x* and *arsenicum 3x* gave slight relief. Next *cedron 1x* was ordered. This cured the pains in four days and was continued for a week, after which there was no return.

CASE II.—A female, aged twenty-four, had endured continuous pain for a week of left side of face and head. The pains were shooting and made worse by hot applications. No teeth seemed to be involved. At first *gelsemium 1x* was tried with transient effect. Next *cedron 1x* was ordered and continued for a week with complete relief to the pain, which did not return.

CASE III.—Mrs. A., aged thirty, for a month past has suffered from severe attacks of left-sided facial neuralgia, recurring every night and morning, and sometimes continuing throughout the night, but not during the day. The pains are dull and gnawing and aggravated by warmth. *Cimicifuga 1x* at first relieved, but then lost its effect. *Cedron 1x* was then tried and continued for two weeks, during which the pain disappeared and has not returned.—*Monthly Hom. Review*, Oct. 1, 1895.





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## THE INDIVIDUALITY OF ARSENIC.

BY WILLIAM BOERICKE, M.D., SAN FRANCISCO, CAL.

(Read before the California State Homœopathic Medical Society.)

THE human organism in health, is an ideal community of separate interests, working together for the common good,—each organ performing perfect work for the benefit of the whole organism and receiving in turn the exact quantity and quality of supplies needful for its functional activity. All is harmony, and consequently health. Introduce a drug and this harmony is disturbed,—disturbed by each drug in a way peculiar to itself; every drug being the embodiment of some distinctive force, the character and quality of which, cannot be known except just in one way, that is, by proving the drug on the healthy human body.

It is the privilege of the physiologist to study man's bodily organization, ensouled with its distinctive life in every part, and it is the special privilege of the homœopathist to study the same living body when influenced and dominated by medicinal forces.

No one before Hahnemann, had imagined that each drug ran

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through the frame and evoked fresh symptoms from organ to organ, that each drug could thus become, an organized entity of symptoms, possessing individuality of its own,—a distinctive character.

This idea is a creation of homœopathy. It was impossible before; useless as well before *similia similibus curantur*, the law of drug selection was practically applied. For purposes of homœopathy, the general indications that are sufficient to the old school, are found to be insufficient. For us a much more minute knowledge is required, which when obtained, will enable us to determine, to some extent at least, the drug's individuality. Proving on the healthy alone, reveals a drug's peculiar disease-producing power. Then by the Hahnemannian application of the law of cure, and by the marvellously simple pharmaceutical procedures, we are enabled to convert this disease-producing power into a healing influence,—a disease-curing power. We are enabled thereby to convert malignant into benign forces, reminding us of the words of Mephistopheles, who when asked who he was, replied, "I am that power that ever seeks to do evil, yet accomplishes good." "Ich bin dis Kraft die stets das Boese will und doch das Gute Schafft."

The individuality of a drug, when known, is the determining factor, the court of final appeal, as to the value of all the symptoms. As in diagnosis, similar symptoms may mean wholly different things, dependent as they may be on different pathological causes, so similar symptoms may be guiding ones or not as they correspond to the genius of a drug and express its individuality. Thus the congestive symptoms of aconite and of iron, may bear and do bear much outward resemblance, but we know in the one case they express a true plethora and in the other a pseudo plethora; in the one a sthenic inflammatory condition, in the other an asthenic one, with corresponding differing applications.

What homœopathist, at all removed from the crude methods of the old school, does not at the mere mention of arsenic, have a distinct mental picture unmistakably characteristic, that close observation at the bedside in time chisels into cameo-like clear cut outlines?

From a study of the provings and the clinical experience of

a century of homœopathy, we are enabled to familiarize ourselves with the individuality of this greatest of drugs—arsenic.

We cannot imagine a more determined enemy to every manifestation of healthy life than arsenic. Its sphere of action extends over every organ and system of organs of the living frame. From the very full and thorough provings we have of the drug, we can see and infer that in its essence, arsenic must be the embodiment of a terribly obstructive and destructive influence, one not satisfied with mere functional disturbance of the life of the organism, but poisoning and disintegrating the blood, thus destroying the source of organic life; or again setting up insurrectionary currents of self seeking life in individual organs, which in consequence fail to serve the whole economy and set up local centres of perverted function, favoring thus the production of tumors and cancerous degeneration. A destructive tendency of the whole, or of a part seems to be the special field of arsenic.

Such malignant force, seeks a corresponding environment, in which it revels and where it can produce its most characteristic work. You know all drugs choose certain temperaments and constitutions, certain states of the weather and certain times of the days and season, in which they are especially active. Such favoring conditions or modalities, give full play to the peculiar activity of the drug. They give us the most important guiding symptoms. Some of these are very characteristic in arsenic.

A special favorable ground for the action of arsenic, is the blood poisoned by malaria, by decayed or morbid animal matter, by malignant morbid germs, or the ground prepared by ptomaines.

A body, worn out by chronic disease, by malignant growths, or brought to rapid prostration and sudden collapse by the invasion of some violent acute disease. While the body is thus racked and ruined, the mind is taken possession of by the diabolical arsenic force. A terrible anxiety,—despair of life, and yet absolute fear of death torture the poor victim, until the end. Such is the type in its extreme form of arsenic, as a disease-producing force. Let us examine analytically, some of the special features of this remarkable drug force.

The first general condition expressing the drug's individuality

is an all pervading debility-adynamic. Before it has time to change greatly the quality of the current of the victim's life, it diminishes his vital energy. Hence weakness, prostration, lassitude. They are so peculiar to arsenic, that as Hahnemann says, even unimportant and otherwise trifling circumstances produce a constant and complete sinking of the strength of an individual laboring under a disease indicating arsenic. This sudden and rapid sinking of the life forces, this asthenic state, is most characteristic. It characterizes the whole symptomatology of arsenic. *Great exhaustion after the slightest exertion, is the key-note.* It may be a mere sensation of weakness, or it may be that, increasing to paralysis and total collapse of strength as seen in some cases of arsenical poisoning, in which there are few signs of irritation in any part of the alimentary canal, but the patient is chiefly affected with excessive prostration of strength and frequent fainting, death coming on in five or six hours. An analogous condition, we find in certain diseases, diphtheria and especially grippe, where prostration seems quite out of proportion to the disorder which accompanies it, and we all know the homœopathicity of arsenic here.

But, this is but one-half of the picture. Intimately associated with this debility, is a peculiar *irritability of fibre*, and hence we obtain, as a perfect expression of the arsenic state, a condition of *irritable weakness*, shown by great restlessness.

We have all watched some caged wild beast—its continuous restlessness; this is the arsenic spirit. It is present and prominent in the worst arsenic cases. Death may be near, the patient worn out, but there is no quiet peaceful anticipation of the end; only anxiety, restlessness, frequent and constant change of position, violent delirium; even when the patient lies in stupor, this is broken by anxious moans and restlessness. No peaceful sleep soothes him. He jerks and starts and his dreams are frightful and fantastic. The arsenic restlessness, is an irritability of fibre, of flesh, bone, brain and mind. He moves constantly. He goes from chair to bed, from bed to chair, from one room to another. When too weak to escape the anxiety by moving about, and arsenic weakness sets in, the most horrible picture of fear and despair is depicted in his face, a mental and bodily horror.

The irritability of fibre, expressed as bodily and especially

mental restlessness, is arsenic's most characteristic feature. Have you a patient worn out by disease, weak, anaemic, prostrated, going deathward, just the case for arsenic, you think. It is, if he has this restlessness, this irritability of fibre. But if he is quiet, apathetic, indifferent, stupid, it is not arsenic, though you may point out to me ninety-nine other arsenic symptoms, yet the very soul of these symptoms is lacking, their very meaning and application to this case, is lost, if this great feature of arsenic is not present. But it is in the mental symptoms, that the individuality of arsenic is most graphically exhibited. The mental condition of arsenic is the principal fact from which the remainder flow organically and logically; it is the common denominator of them all.

#### MENTAL SYMPTOMS OF ARSENIC.

We find in arsenic a great amount of anguish—the greater the suffering the greater the anguish. Great restlessness.

Fear of death. Fears to be left alone, lest he should do himself bodily harm. Great fear with cold sweats, cannot find rest anywhere. Is intensely suicidal. Feels that it is useless to take medicine as he is surely going to die. Melancholy, intense anxiety.

Patient has hallucinations of smell; smells pitch and sulphur; it is the arsenic foretaste of immortality for he anticipates confinement in hell.

Now how are you going to distinguish aconite?

It is restless, fearful, afraid of death. The two remedies are wholly different. Aconite is a sthenic remedy, the blood rushes through the organism, bounding and throbbing—a healthy blood, but excited, inflamed. Arsenic on the other hand, has a depleted system, a poisoned blood, a disorganized blood, insurrection in some part of the organ has taken place, a cancerous anarchy established in some region or organ, its excitement, anguish, restlessness is based upon its nervous exhaustion, its worn out condition, it's a cry for healthy blood; therefore the arsenic patient is cold and chilly and weak, nervous and sensitive. Do you wonder at his longing for death; his suicidal tendency—his despair that makes him imagine that he must die—the despair driving him from place to place—he wrings his hands, he is going to mutilate himself, kill him-

self, this very night, after midnight, the last part of the night, so great is his despair of life; *but his excessive fear of death* is even greater. He is a coward at heart. He fears not only death, but ghosts and thieves. He hears voices, sees demons, rats, mice, bugs, worms, from which he attempts to escape by hiding.

Such a mental state we frequently encounter from causes that have greatly exhausted and debilitated the patient's general condition, as from anxiety, overwork, loss of sleep, chronic digestive troubles, etc.

Again, the typical arsenic mind is miserly, covetous, malicious; morbidly bent on money-making; he lacks moral courage, intensely selfish, cherishes none of the finer feelings of human nature—hence his diseases are correspondingly repulsive—ulcers, cancers, degenerations, etc.

Clinically, we find that the longer a disease has lasted, the more deeply the organs and tissues have become affected, the more certainly deathward the tendency, the more surely will arsenic be indicated. Now, on the contrary, arsenic is but rarely the remedy in the beginning of disease, unless it be in a disease characterized by similar *rapid and sudden prostration*; but, as a rule, it comes in later, after other remedies.

I have already pointed out the tendency of arsenic to local insurrection against the well-being of the organism as a whole. It favors strikes in certain districts. Arsenic is full in its symptomatology of such local anæmias, cutting off the supplies necessary for the functional activity of any organ or series of organs, and thus, in consequence, arsenic has a tendency to produce ulcerations, or molecular death, gangrenous ulcers, ulcers with black sloughs; edges turn black, with almost constant burning in ulcers, burning watery discharges from them.

All the stages, therefore, from slight disorders in the vegetative sphere to the production of dyscrasia, cachexia, decomposition and dissolution of the organic tissue—gangrene—are the legitimate field for arsenic, and homœopathy avails itself of this potent drug in these conditions when the constitutional symptoms call for it, independent of merely local indications, the constitutional symptoms being those expressive of the individuality of the drug. As a general designation, Hughes speaks of this special characteristic feature of arsenic as *ma-*

*lignity*, by which is meant that condition which may appear in any acute disease—scarlatina, diphtheria—a condition especially shown by darkened color of the blood and fetor of its excretions and exudates, with corresponding prostration and disorder of the nervous system. In all fevers, eruptive diseases and inflammations, where this tendency to putrescence and decomposition shows itself—a condition common to all acids and some animal poisons—arsenic is one of the chief remedies to bear in mind, provided the special symptoms present indicate it.

It will be found to correspond to many forms of destruction of tissue common to cancerous formations; here the rapid emaciation, in spite of fair appetite, points to it. This progressive emaciation, more or less rapid, when the patient is eating well and there is no sufficient cause for it, is peculiar to arsenic and to iodine. It is a suspicious symptom, and should always attract the physician's attention.

With this feature of malignity, we can pass on to the peculiar arsenic sensation, which is pre-eminently burning—burning pains and sensations everywhere; intense burning, as from coals of fire, in abdominal cavity, in skin, in mouth, throat, in chest, stomach, in mucous membranes generally, in its ulcers and vesicles and swellings—burning sensation everywhere; the affected parts burn like fire, still wants to be covered up warmly. There is a burning thirst; it is an early and very marked symptom of its action on the healthy body, and is always present in febrile states to which it is suitable. One proving gives it as follows: “Thirst so violent that he drank eleven jugs of water in half a day.” Now, with this great burning thirst, it produces a very irritable state of the stomach—a true gastritis—and hence but a small quantity of water can be taken at a time; hence, the further clinical feature of the arsenic thirst—little and often—a very short time between drinks. Remember that the burning, unquenchable thirst for cold water drinks frequently, but little at a time; the stomach cannot tolerate or assimilate much cold water. So while the patient may greatly long for it, he cannot drink it except in sips; he wants to moisten lips and mouth frequently.

We all know the great importance of modalities in making a homœopathic prescription—the conditions of aggravation and

amelioration. They are especially important and pronounced in arsenic.

1. The symptoms are worse at night, especially after midnight—1-3 A.M. Now the restlessness, the anxiety, the cough, the diarrhoea, pains, itching and burning, the asthma, the valvular troubles—in short, any peculiar arsenic condition—are then apt to be worse.

2. *Worse at rest.* We can readily see this if we bear in mind the irritability of the drug. He cannot rest in any place, changes position continually; he imagines he gets some relief by so doing. Lying down greatly aggravates coughing and breathing.

3. *Worse from cold.* Especially marked is this in the neuralgia, calling for arsenic during night and by cold air infringing on the surface. Cold weather increases troubles, cold food and ices; arsenic is a cold remedy. Skin is pale and cold, patient is cold or chilly, hence the amelioration.

4. *Better by warmth.* Arsenic particularly likes to sleep between lots of bedclothes, even in summer. He hugs the fire; it is one of the great comforts of his suffering life. He likes a hot-water bottle. Arsenic always wants to be wrapped up warm, wants warm things—drinks, etc.

*Periodicity.* This is another characteristic feature of the peculiarities of this drug's action. It is one of the few medicines capable of inducing a true recurrent fever and remissions, intermissions, and more or less regular returns of the symptoms are noted by all observers.

Periodic recurrence is thus a true feature of its pathogenic influence. In typical diseases of all kinds, says Hahnemann, the type-exciting property of arsenic in small doses becomes valuable. Complaints return annually, every two weeks. It is one of the great remedies for malarial poison—possibly the greatest for the cachexia, as well as for many typically-returning affections. The type itself is changeable, and the intermissions are rarely entirely pure.

Such are the chief features of this wonderfully distinctive drug force, as manifested, when given full sway in the comparatively healthy body. Such are the general indications for the use of arsenic whenever met with in diseased conditions.

The 1281 symptoms recorded in Hahnemann's *Chronic Diseases* as belonging to arsenic are interpreted and simplified, and justified as well, by the recognition of the genius, the individuality of arsenic, of which they bear witness and which they express in 1281 different voices.

We see, thus, that when we enter the realm of *materia medica* through the gate of drug-proving on the healthy, and guided by the law of similars, we find ourselves on a great mental highway leading to practical uses of drugs based upon recognition of their distinctive organic individuality.

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#### GLONOINE IN SCIATICA.

BY E. M. HALE, M.D., CHICAGO, ILL.

FROM time to time, during the last year, there has appeared in old-school journals cases of sciatica alleged to have been cured by nitro-glycerine. In nearly all the cases, however, it had been combined with some other drug—bromides, capsicum, salicylate of soda, valerian, etc.—making the reports all but worthless. But, in a few cases, it was evident that the relief and cure was really due to the glonoine; notably, one case, “a woman of 45, with atheromatous arteries, associated with atrophy of the muscles and hyperæsthesia.”

This case gives us a trustworthy indication for the use of the drug, not strictly according to the law of *similia*—for glonoine could never cause atheroma. Those who know its value in angio-spastic neuralgia of the head and face, need not be surprised at its power over sciatica in atheromatous subjects, or in persons whose vaso-motor centres are in such an irritable state as to cause spasm of the arterioles.

In spastic hæmicephalia, the face is cold and pale, the expression anxious, and there is sensitiveness to noise; the pulse is hard and small, and the temporal arteries rigid. In angio-spastic sciatica, the limb is cold, shriveled, with hyperæsthesia, and, in old cases, atrophy.

In such cases, glonoine cures by its power over the vaso-motor nerves, forcing them to relax their constrictive action on the bloodvessels. Under its physiological influence, the blood-

vessels relax, dilate, and allow the arterial blood to fill them, when the pain ceases. For this purpose, low dilutions are required, but there is no fixed dose; some patients respond to the 3c., 2c., and some require the 1c. ( $\frac{1}{10}$  of a grain); but I have had patients who got relief only from the  $\frac{1}{50}$ ; and, in several cases, large doses, such as  $\frac{1}{10}$  grain were required. Cases are reported where 1 and 2 grains daily were required.

When such large doses are needed, the arteries were atheromatous to a large degree, rigid from calcareous degeneration of their coats; while in purely functional vaso-motor spasms, the 3c. is often efficient. The same rule holds good in cases of heart failure. In urgent cases, hypodermic injections should be resorted to.

The question now arises—is glonoine ever primarily indicated? On referring to Allen's *Encyclopædia of Materia Medica*, the following symptoms are found:

“Great weakness in the middle portion of thighs, with trembling of the limbs. The limbs go to sleep easily. Uneasiness in the limbs, impelling him to rise as often as he sat down. Extremities feel bloated. Sharp, pricking pains in legs; weakness and numbness in left thigh and leg. Sensation of weakness in the left thigh, and a pain from the buttocks to the heel on the interior side, along the course of the ischiatic nerve, most violent in the calf (second day).”

Nearly all these symptoms are common to sciatica. The last symptom would be important if the one prover never had experienced such a pain previously. This prover was Mrs. St., who took the  $\frac{1}{200}$ , and afterwards the  $\frac{1}{50}$  of a grain. It would be more valuable if other provers had experienced the same or a similar symptom.

We all know the graphic primary indications for glonoine in headache—the throbbing, fulness, bursting, heaviness, etc.—and we often prescribe it in the 6th, and higher, with apparent good results. We call such cases congestive headache, which is correct, if congestion is a proper designation for the vaso-motor dilatation of the bloodvessels of the head. It seems to me, that the headache of glonoine is due to a mechanical pressure of the gorged bloodvessels on the surrounding tissues, at the same time the blood pressure, the *vis a tergo*, from the heart is really lessened.

If homœopathic to sciatica (primarily) the following symptoms would indicate it: Sensation of throbbing, fulness, numbness, weakness, heaviness, and great uneasiness in the leg. The first stage of inflammation of the tissue surrounding the nerve, with heat along its course, would call for the use of glonoine in doses above the 3c.

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## SOME REMEDIES IN SUPPURATION.

BY PROF. WILLIAM E. LEONARD, M.D., MINNEAPOLIS, MINN.

(Read before the Northwestern Academy of Homœopathic Surgeons, Sept. 19, 1895.)

LET the student of our therapeutics take up any repertory or hand-book of treatment, medical or surgical, and under the caption of abscess or suppuration he will always find mentioned, in large type, belladonna, hepar, mercury and silicia. I will not waste the time of so intelligent a company of practitioners as this by detailing the use of these every-day remedies, but will rather call your attention to some less common indications for remedies which you may need to control the formation of pus. It is only fair to preface this paper with the statement that I have endeavored to cull from many legitimate sources, and that the arrangement is my own, as being both attractive and practical. It has not been my good fortune to confirm many of these usages, but those who have made the records are reliable observers.

### I.—SUPPURATION IN GENERAL.

A. *Acute.*—You all know how to use aconite and bell., but the virtues of arnica are too often overlooked. Grauvogl said that it prevented the formation of pus by withdrawing water from the serum, as shown by the increase of the watery contents of the urine without increased drinking during its administration. Be this theory correct or not, its power to adjust the capillary circulation after a bruise or contusion is undoubted, and that very adjustment prevents suppuration, as you have all observed. But, further than this, arnica is the remedy, above all others, when from the general debility and foul secretions,

with probably ecchymosis and gangrenous spots, there is reason to believe that pus is forming and burrowing in any part, but without pain. Here, other general indications for the drug will be present, and its power to check suppuration be brilliantly made manifest by its administration. I have several times seen arnica dry up a crop of small so-called "blood boils," appearing one after the other, with no other especial indication except their extreme soreness. In carbuncles it is an early remedy, but perhaps not of the same value later as lachesis or anthracium.

*Bryonia*.—While we most often think of this every-day remedy for acute inflammation of serous and mucous membranes, it has an excellent record in suppuration of cellular tissue and as a resorptive of pus in acute abscesses. The indications for its use are the general ones of pale redness and swelling and the extreme aggravation from motion or touch, without the high grade of inflammation and the rapidity characterizing bell., or the more acute and earlier indicated aconite. In felon, bry. has aborted where early the inflammation is light or pale red, diffused, not hard nor burning, but with tearing and shooting pains. Not only is there local dry heat, but the dry mouth, the bitter taste, the coated tongue and a frequent strong pulse, with other general symptoms for the drug, shows that the local inflammation tends to involve the whole circulation and result in suppuration.

While the use of arsenicum is by no means confined to acute suppuration, it should be remembered when inflammations suddenly develop burning or lancinating pains and acrid discharges. The acute suppurations to which it applies occur generally in connection with anæmia of some sort, with attendant emaciation and debility, *i.e.*, general arsenicum conditions.

Occasionally the accompaniments, especially of cellular inflammation, with scanty, thin and corroding pus, are such as to indicate chamomilla, the indications upon which it has cured being well-known excessive sensibility and irritability of fibre.

While we usually think first of hepar for laudable pus, we should not forget pulsatilla upon the same indication, viz., very profuse, greenish-yellow or bloody but unirritating pus. In abscesses with such discharges the pains of pulsatilla are stinging

and cutting, often with chilliness (again like hepar) and thirstlessness and oppression of the chest. The parts bleed easily and are surrounded by bluish-red swelling (varices). Puls. is one of the group of medicines to be mentioned hereafter as suited to suppuration of internal parts, being indicated especially upon the well-corroborated proven symptom, "pain as from subcutaneous ulceration or festering," also for glandular suppuration. Puls. should not be forgotten for periostitis when its general conditions of anaemia, weak venous circulation, etc., are present.

Another remedy for acute suppuration is rhus. Oculists could not do without it for orbital cellulitis, and it has done good service in the general cellulitis sometimes accompanying diphtheria. In a series of bloody abscesses where the child was quite covered with boils, it proved curative, and it has often aborted carbuncles, if given early, when the pains were intense and the affected parts dark red. Its action upon the glands in suppuration is well proven, especially the parotid and axillary, when the pus is bloody and serous and the pain intense, gnawing, or before there is any discharge, when there is intense pain and a dark red swelling as above.

These brief outlines will call to your minds the uses of arnica, bryonia, puls., arsen., rhus and cham. in acute suppuration.

B.—In chronic suppuration the list is made longer, nor shall I attempt to include all useful drugs except the well-known hepar, merc. and silicea. Perhaps first on the list should come calcarea carbonica, because of its general applicability to a great variety of scrofulous inflammations, especially of the glands. Its pus is generally albuminous, whitish-yellow, copious and bland, or it may be scanty and putrid. In the pyæmia of rickety or scrofulous children, it is the great remedy, the general constitutional symptoms being then better indications than those afforded by the local point of suppuration. Especially in the second stage of hip-joint disease, and in white swelling of the knees in flabby calcareous children, has this drug made a fine record.

Sulphur is another remedy of very wide applicability in suppurative ailments, and while it is indicated upon its many well-known generalities, it should be especially remembered

when all the discharges of the body, including the pus, are acrid and excoriating, and the pus is also then black and putrid. Probably its best record is for crops of boils in various parts of the body, very painful, with inflamed base, discharging finally an unhealthy, sometimes bloody, pus. This crop heals up and is followed by another, or single ones succeed each other. From these often corroborated conditions it would seem that our grandmothers were not far wrong, and only a little crude in their methods, when they gave liberal doses of "treacle," sulphur and molasses, for the blood in the spring. Undoubtedly, the great virtue of hepar in all suppurative conditions lies in its being a happy combination of these two great drugs, calc. carb. and sulphur, but it cannot take the place of either where general conditions plainly call for them, as each careful prescriber knows.

Less often thought of or indicated is lycopodium. It has been found curative of boils returning periodically, when warm poultices aggravate all the pains; also carbuncles, with burning stitches all round, with alternate chilliness and heat of body; pus bloody, corroding and putrid; in glandular swelling and those of tubercular or deep-seated chronic nature.

## II.—LOCAL SUPPURATION.

Under this somewhat anomalous heading, I would group a few drugs especially applicable to suppurative processes in special tissues.

A. *Skin.*—The indication, "small wounds suppurate and do not heal," is a most useful and reliable one for hepar, calc. carb. and graphitis. The latter drug, graphitis, has made its great record in causing absorption of old, hard scars or cicatrices and of tumors of the scalp, which are generally found in people of herpetic dyscrasia, which tumors are commonly sebaceous, and if they begin to break down, discharge a scanty pus of herring-brine odor.

B. *Glands.*—Here we find a long list of drugs, with merc., sulphur, silicea and graphites leading. To these should be added:

1. *Nitric Acid.*—When tedious suppuration involves the inguinal or axillary glands, especially in mercurial or syphilitic

subjects, and the discharges are then offensive, excoriating and of a dirty greenish-yellow color, never laudable.

2. *Kali Iodata*.—Especially applicable to chronic suppuration of the glands anywhere, when the discharge is thin, corrosive, or curdy, and the indolent, hard edges betoken obstinacy and probably a scrofulous or syphilitic background. Not only does this drug suit glandular inflammation but also diseases of the periosteum and the capsular ligaments of the joints, and caries and necrosis of the bones themselves. Its curative action here is undoubtedly even in the large doses of current medicine.

3. *The Carbons*.—Carbo. animalis applies especially to the inflamed and indurated glands of scrofula with lancinating and burning pains; while carbo. vegetabilis seems to be most useful later, when suppuration of a low type has begun in such glands and constitutions, and sepsis or pyæmia threatens with hectic, sunken features, etc.

4. *Phosphorus*.—While this drug is most often thought of and used in necrosis of the bones, especially in late hip-joint disease, it also cures glandular swellings in weak scrofulous patients, who suffer much from diarrhœa, hectic fever and colliquative sweats. The lymphatic abscesses of phos., are full of fistulæ, callous, and discharge a copious yellow pus.

5. *Cistus Canadensis*.—This, the rockrose or frostweed, is an old time domestic remedy for all kinds of scrofulous diseases, and deserves especial mention for its well-authenticated use in swollen, indurated and suppurating glands; also the caries of scrofulous subjects. If we may believe the record, it should be used more than it is.

C. *Bones*.—Besides phos. and puls., the uses of which in inflammation of osseous and periosteal tissue have been given, the following deserve especial mention.

1. *Aurum*.—In caries of the bones, especially after mercury, in syphilitic patients, when the nightly boring pains drive the patient to despair.

2. *Asafætida*.—Osteitis, especially syphilitic, when there is caries and bluish redness and swelling of the parts, with nightly bone pains; its ulcers are deep, exquisitely sensitive, and the discharges fetid and ichorous.

3. *Calcarea Phosphorica*.—This constituent of bones is a prominent remedy for caries of the same, and especially suits caries of the hip-joint and heel, with offensive pus.

4. *Calcarea Fluorica* also suits suppuration in bony structures, being quite similar to *silicia* and *calc. phos.*

5. *Manganum*.—This old remedy of Hahnemann is found to modify inflammations of the bones, when there is swelling and suppuration, marked by sensitiveness and red spots on the skin over the bones, the ankles of weakly children being especially affected.

D. *Internal Organs*.—Under this heading the use of *arnica* and *puls.* has been mentioned, but the chief and more commonly indicated drugs for suppuration of internal organs are *lachesis* and *cantharis*, which have each a remarkable record in such deep-seated inflammations as *hepatitis*, *peritonitis*, *pelvic cellulitis*, *typhilitis*, *diaphragmitis*, etc.

In closing let me say that it is quite remarkable how the use of lime in some form for suppuration is now to be found in all therapeutics, all being without doubt founded upon our *hepar*, the use of which originated with Hahnemann in 1825.

Even Dr. Scudder, the chief therapist of the American Eclectic School, in his latest work, *Specific Medication*, extols the sulphite of calcium as specific in inflammation of the superficial connective tissue and hence in boils, furuncles, etc., and advocates a wine-glass full of lime-water, from three to four times daily for the continual development of boils.

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## OPIUM IN PROFUSE AND COLLIQUATIVE SWEATING.

BY F. H. PRITCHARD, M.D., WEAVER'S CORNERS, OHIO.

OPIUM has the peculiarity of checking all the secretions except that of the skin. Its action here was well known to the older writers. "Nothing is better established than the power of opium to excite perspiration," says Burt (*Physiological Materia Medica*, 8d ed., Chicago, 1883). He cites Bonatus, who states that, "we have not any diaphoretic so faithful, so certain, or which so well deserves the name," and Cullen, who declares that "at all times opium has been found to be the most effectual of all sudorifics." A large number of the old stimulant diaphoretics owed their activity to the opium contained in them. In cases of poisoning by this drug a remarkable illus-

tration of its sweat-producing power is observed, for the skin is bathed in a profuse, and sometimes greasy and graveolent sweat while the temperature remains natural or even above it. However, the profuse sweating is not always, and indeed rarely observed except from good sized doses and quite constantly during the third stage or that of prostration. Prof. H. C. Wood, Jr. (*A Treatise on Therapeutics, etc.*, p. 1883, Phila., 1874), after describing the characteristic symptoms of poisoning by opium, in the second stage, which resembles that of congestion of the brain, proceeds: "When the symptoms do not gradually ameliorate, the third stage or that of prostration, is developed. The coma is now profound, and to arouse the patient may be impossible; the pupils are absolutely contracted, or as death approaches, are widely dilated; the respirations are slow, feeble and imperfect, and often interrupted by intervals of death-like quiet; the countenance is at once pallid and cyanosed; the pulse grows more and more rapid and more and more feeble; the skin is cold and moist, finally covered with a clammy sweat."

From moderate doses of the drug the sweating is mostly upon the face and chest; the heat of the skin is increased and remains so as long as the sweat continues, which is usually twenty-four hours. The diaphoretic action is more marked in females than males.

Lewinstein (cited by Kobert, *Lehrbuch Der Intoxikationen*, p. 560, Stuttgart, 1893), calls attention to a peculiar intermittent state which is observed in morphine eaters and which has all the peculiarities of a malarial intermittent as a chill, even a rigor with following heat and sweat; the type varies from quotidian to tertian and the temperature rises as in malaria; the attack may be anteponens or postponens.

Hering also presents similar symptoms which confirm the action of the drug. Bonino (*Primi Studi Di Materia Medica*, p. 262, Turin, Italy, 1893), mentions the remedy as indicated in typhoid fever with profound sopor, stertorous respiration, the lower jaw falls down, the abdomen is distended, with copious, warm and non-critical sweat, which is also of ill portent. My experience with checking exhausting and colliquative sweating was unsatisfactory until I became aware of the value of opium in this state. In the exhausting, long-lasting and distressing

sweats of the critical, the uncertain stages of severe cases of infectious diseases and notably of typhoid fever when the patient though not having reached a critical day breaks out into long lasting, profuse and depressing sweating, and when already weakened by his disease, possibly the loss of such excessive quantities of fluid may be the turning point for the worse. Then not only does the skin seem to throw off the toxines with the sweat but these very toxines appear to cause a paralysis as it were of the cutaneous circulation, that of the brain, and to affect either primarily or secondarily, the heart itself. Here opium will often completely control this ill-omened complication and tide the patient over to recovery. In the sweats of convalescence from typhoid it also acts fully as well. In the profuse sweating following the grippe I have also found it of great value, for it will rapidly control the excessive perspiration. In such a case following the grippe where the patient, a female, who was still in bed but without fever and but little cough, the sweating was so excessive that from five to seven changes of her underclothing were necessary daily, and several changes at night. This condition continued, uninterruptedly, for several days when various remedies having failed, I chanced to recall the diaphoretic action of opium, and I thought that I should try the remedy. I gave ten drops of the tincture of opium in four ounces of water and directed a teaspoonful to be taken hourly. The following day only three changes were necessary and from then on the patient picked up strength and was in a few days able to be out of bed whence she made an uneventful recovery.

I have never tried the remedy in the night sweats of pulmonary tuberculosis.

Though the dose might be considered large still I think that it acted according to the law of similars. The small dose is not always necessary in homœopathy. For example, the iodide of potash will act if given homœopathically but the dose must frequently be material. Prof. Lilenthal, several years ago, in commenting upon an allopathic cure, which was really homœopathic, with this drug, pointed out this feature. As Jousset, of Paris states, the essential point is "une dose non-perturbatrice," a non-disturbing dose. Is it not possible that to get results from certain homœopathic indications, massive doses may be

called for? That is a point which I have frequently discussed with homœopaths and upon which there seems to be a certain amount of obscurity. To remove other sets or series of symptoms, a higher attenuation would be required. The tincture of opium will control the sweating but it will certainly constipate, as I have observed. I know of a case of profuse sweating in an opium eater where jaborandi removed this symptom.

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## THE CACTACEÆ, WITH PARTICULAR REFERENCE TO PHYLLOCACTUS.

BY E. H. HILL, M.D., TUNKHANNOCK, PA.

I DESIRE to call attention to the cactus family, and particularly to a new preparation for medicinal use made from one of the phyllocacti. The family cactaceæ includes a great variety of species, more than five hundred having been discovered. A firm in Philadelphia, who make a specialty of raising cacti, claim to have seven hundred varieties, some of which, however, have been developed by grafting. About fifty varieties have their habitat within the United States, many more in Mexico and South America countries, and a few in the West Indies. The family includes plants in size, all the way from the minute bulbous varieties and creepers to the giant cactus which often grows to forty, fifty, and even sixty feet in height.

Many uses have been made of the cacti by the inhabitants of the countries in which they grow. Some varieties are used to build fences, which are impenetrable to man or beast. The beautiful wood of the candle-cactus is used for making elegant pieces of furniture, canes, and other articles. The lumber of the giant cactus is used to build huts. Cattle eat the young leaves of many varieties. The seed-pods of some varieties are large and succulent, and are used for food, while those of other varieties are used to prepare a drink, very much the same as lemons are used to make lemonade. One variety has a fig-like fruit, which the natives fry into cakes and eat. Another variety can be made to produce a good drink by cutting of the plant so as to have a basin in the top which soon fills with its juice. It is said that a Mexican will not pass a cactus tuberosa without pulling up the root, which he soaks in alcohol to be used in

bathing parts of the body affected with rheumatism. Young stems of *cereus grandiflora* are extensively used in making hair tonics.

Cactus was introduced to homœopathic physicians as a medicine many years ago by Dr. Rubini, of Italy. The variety used was *cereus grandiflorus*. In the preparation of the tincture our pharmacopœia directs us to obtain the fresh flowers, youngest and tenderest stems, gathered from plants growing in their native country. I have not followed these directions in preparing the tincture I wish to introduce to you this evening, but have used the flowers and flower-stems only of a variety of *phyllocaactus* under cultivation. Neither have I followed the directions of the pharmacopœia in regard to the amount of alcohol and plant to be used, but have prepared my tincture by putting the flowers and flower-stems in a jar, covering them with alcohol, after which the jar is closed tightly and kept in a dark place for two weeks; the tincture obtained by filtering; 95 per cent. alcohol was used; and the flowers were obtained near midnight when at their fullest development. It is not difficult to detect the delightful odor of the flowers in this tincture, and I think this aroma is always present if the tincture develops its fullest effects.

Recently, the liquid extract of *cactus grandiflorus* has been used quite extensively by allopathic physicians, and is said to be sedative to the circulation, and a diuretic, useful in heart-trouble attended with much irregularity of action, palpitation, cardiac neuralgia, angina pectoris, rheumatism, valvular diseases, haemoptysis, and dropsy. Cactus is another of their new and good remedies, in fact, like *cupri arsenitis*, *rhus*, and others. Their dosage varies from 10 to 30 minims.

Cactus was thought, by Dr. Rubini, to be a rival of aconite, producing, as it did, general rigor followed by heat and sweat, marked periodicity of symptoms, acute congestion in head and chest as evidenced by pain and haemorrhage, quickened circulation and respiration, all symptoms of inflammatory fever, for which aconite is so useful. But the greatest value of cactus is in the treatment of disturbances of the circulation, particularly when the great force-pump, the heart, is at fault. Both the pathogenetic symptoms produced by the drug and the clinical experience with it, proves its efficacy in these troubles.

Such symptoms as, oppressed breathing; palpitation; pulsation at pit of stomach; painful pressure in vertex; cramps and stiches in cardiac region; the well-known band-like constriction; quick pulse, very irregular and intermittent; and profound melancholia, are very significant symptoms, often met with in practice, and cured with cactus.

I do not wish to claim for my preparation of cactus any superiority over the cactus grandiflorus as prepared by our pharmacists, but do claim that it will do all that cactus grand. will do; as I know, from five years' experience with the drug; is easy to procure and manufacture, and hence we can always have a perfectly reliable preparation at hand.

I use most often No. 35 pills, saturated with the tincture, but sometimes give 20 or 30 gtt. in tumbler three-fourths full of water, in teaspoonful doses, as often as the severity of the case seems to require.

Allow me to cite one case treated with phyllocactus last week:

Prof. S., school-teacher, graduate of Harvard College, a great student, and young man of most excellent habits, presented the following symptoms: Unable to sleep because of constant palpitation of heart; some pain, and marked constriction about the heart; oppressed and quick breathing; occasionally very violent beating of heart, followed by weak feelings; great mental depression; gloomy, feels as if health would give out entirely; sees only the dark side of everything. On examination of the heart with stethoscope, no murmurs were detected, but the pulsations were very irregular and quick, about every fourth beat entirely absent. No. 35 sugar pellets, saturated with phyllocactus tincture, was given. In twenty-four hours my patient was much better, and is now visiting in Cambridge, Mass.

I have treated this patient previously several times for like attacks, always using cactus, with results most gratifying.

**LEECHES AS A CAUSE OF MENORRHAGIA**—E. Borysapolsky.—The patient had been taking a sea bath, and had sat down on the sand in the water. She began to flow profusely when she left the water, and she became collapsed and very anæmic in two hours. Two large leeches were found in the vagina and four were attached to the vulva. These were removed, a tampon inserted to control the bleeding and the woman made a slow recovery from her anæmic condition. A most excellent method of removing leeches from the vagina or from the uterine cavity is to inject salt and water.—*Centralblatt für Gynacology*, No. 43, 1895.

## A PLEA FOR PURER PRACTICE.

BY Z. T. MILLER, M.D., PITTSBURG, PA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania.)

If a gentleman of fine discrimination, halts you on a side hill, while the thermometer is ranging 98 in the shade, the sun vying with his hair, as to redness, to the rippling of rivulets of perspiration chasing each other for channel place adown your back, makes plaintive plea for a contribution to the Society TRANSACTIONS, could you resist? Such tickling of vanity, such encouragement to self-sacrifice, such fiery recognition of the blaze of genius that you yourself know burns ever 'neath the buttons of your coat, quite overcomes the determination to be taught and not teach, so that you poke the smouldering embers and blow that dull redness of indifference into renewed life. Whether this heat will warm you, whether in the curling smoke you will recognize an image long forgotten, or whether in the after ashes you see but the remains of a senseless structure, depends entirely upon the depth to which the principles underlying the homœopathic faith are graven upon your soul, and how responsive you are to the facts of that faith. The song has oft been sung, and I deplore the conditions that seem to make successive intonings necessary. Yet does any one deny that there is any occasion for viewing with alarm the partial and sometimes total disregard of the fundamental tenets of our creed? Does a review of recent publications, book or pamphlet, assure us that the writers are as thoroughly imbued with the truth of Hahnemann's teachings as was Hahnemann himself? Does the published practice prove that similia has entirely displaced the uncertain methods of those unfamiliar with a law of cure? Does the simplicity of the single similar put to shame the ways and means of manufacturing pharmacist, and if not, *who* shall say: "Stop! we'll have no more of the old story?"

The duty of a man is to know what is right and do it. To know it and not do it, is a crime. To not know it when the opportunity is present is worse than a crime; it's an unpardonable sin when human life is concerned.

There is connected with this business of acquiring knowledge of *materia medica* a responsibility that never ends. The dawn of to-day, the twilight to-night, are but the beginnings of a task that compasses the lifetime of the man who seeks, and while he may look back and see where successes may have materialized, the ever-growing number of conflicts ahead impress him with the thought that it's *all beginning and no end*.

I pity the people served by the man who knows enough. I sympathize with the homœopathic expectant who falls into the hands of a man who knows *better* than Hahnemann. If life is too short to study homœopathic *materia medica*, it is to be feared that *other* lives are shortened by the system that a life *can* master.

The deplorable thing in this business is the utter neglect of the ample opportunity presented to firmly establish as truth what seems, to some, questionable data. I refer to our hospitals. Confirmations should be carefully noted and tabulated. Potencies of all scales should be tested, the time of administration with the first appearance of relief, if any, should be stated. Everything pertaining to the establishment of certain knowledge, with the details of which you are quite familiar, should be matters of greatest moment, but they are not. The hospital is the only place where this accuracy can obtain, because it is the *only* place where perfect and complete control of the patient is possible. In private practice no doctor knows what neighboring old lady may be supplementing his own well directed effort with a favorite tea, cure-all pill, or other meddlesome interference that invalidates an otherwise seeming good, hence the reports from private practice are not always reliable.

But the hospital system can hardly be looked to for deliverance unless they are run on lines quite other than those now in force. If you will take a peep at the pharmacy from which remedies are dispensed, you will have your homœo-allo-electic heart gladdened by the size of the bottles, the color of the contents, the stench of correctors, for they are all there, while the poor little phials of  $\frac{1}{2}$ , 3x, 6x, etc., crawl into the drawers and cover themselves with dust as if ashamed of the company they had got into. Iodoform is king and pervades every nook and corner of the house, its nauseating perfumes penetrate the nostrils of every occupant of the wards, something that Hahne-

mann condemned in the most emphatic manner. Notwithstanding this laxness, our hospitals do the best work, yet what would it not be, if the strictest rules of homœopathic therapy were observed? Think of it, brethren.

The neglect of this opportunity, deplorable as it is, is not entirely inexcusable. The young men who have constant care as internes, are usually just from school and if they know as little as a certain young man I know of who just left school, they cannot boast phenomenal acumen. They are scarcely qualified to apply remedies and note the sequences of the application. The senior physician, from long practice, selects the remedy without much mental calculation and passes to the next. He visits because he agrees to look after the patients a certain number of days each year, which time he gives as hastily as it's possible to do, for more lucrative business awaits him. He too, by reason of gratuity and pressure of time, fails to make the best of this opportunity. Hence neither the interne nor the physician attending, seem adapted to the obtaining of such results in hospital practice as the profession at large have a reason and right to expect. Hospitals are largely the children of private and State beneficence, and private and State beneficence is abused, if the very best results are not obtained and the very best management carried out. If a homœopathic institution is endowed by private means, and chartered by the State, the presumption is that that institution is to be an establishment conducted upon the principles enunciated and promulgated by the founder of the homœopathic art. Anything short of it, or contrary to it, is a species of fraud and a betrayal of a trust both private and public.

But, says my friend, if Hahnemann had lived to-day, he would have been abreast of the modern methods, and would have modified many of his arbitrary rules regarding practice. I do not think so. A fact is a fact yesterday, to-day and forever. If like cures like because it is the dictum of unchanging nature that it should, then there can be no change, however much the sluggard would have it so.

Every one of you has demonstrated to the fullest satisfaction that the potentized drug cures disease, not once, but all the time, under similar circumstances. Shall you turn from that certainty and trifle with uncertainties? Every one of you

knows that the single remedy bears you more intelligent evidence than the multiple. Shall you grope mid the uncertainty of alternation? Every one of you knows that disease attacks in varying force, and that varying force is required to combat it. Then will you wield the sledge in every case, when the gentler vibration of insensible molecular motion would be sufficient? In other words, use the lowest to highest potencies compatible with cures.

With this mode of cure there can be no compromise. Homœopathy is either dead right or dead wrong; it is everything or it's nothing.

Do not understand me as conveying the idea that our hospitals are bad unto condemnation. Nothing is farther from my intention. The splendid men who plan, rear and manage are a noble set of fellows, and deserve credit for doing what has not fallen in the province of many of us to do. The fact that they possess great parts makes their neglect the greater. The possibility of achieving perfect success renders an indifference to that attainment the more apparent.

It is distressing to hear about the imperfections, incompleteness of our *materia medica* when the opportunity for correcting those shortcomings is rather contemptuously treated. A clientele so vast as that following the practice of a professedly lame system shows what a potentiality for good really does exist, and the whole thing is a vain delusion, a something that tickles the fancy of the sick—while they naturally recover—and deserves to be abandoned unless that potentiality be developed to the fullest extent by the people having the healing art as a life-work.

Many fanciful methods have recently received the sanction of eminence, soon to be dropped. While just at present the mechanical causes of reflexes commands much enthusiastic attention, it, too, is likely to fall into the limited field of its adaptability. Not so with Homœopathy. Nothing supplants it, nothing crowds it out save the laziness of those who falsely float its banner.

Lax methods will mix acon. 1x and bell. 1x in the same bottle for a cold, but just why it is done I am unable to define, save for the aforesaid tickling of the fancy; for surely no one would claim it as homœopathy. The spirit of careless indifference

that makes such practice, possibly is fast undermining the lawful system and placing it upon a par with the rankest of medical proceedings. Yet Homœopathy is not defiled; the man so practising is the lame duck.

The psychological aspect of men and men has much to do with allegiance to faith. Some men cannot stand ridicule; some flunk before flattery; others are indolent. The first cannot give a *reason* for their faith; the second have no faith, and, like the weather-cock, turn their heads to the wind of flattery that blows hardest; the third—well the third are hardly worth considering.

Men who have occupied the front rank in our school have sons now practising in the allopathic ranks. One particular instance I could name makes me wonder how it was possible for such a masterly father to have a son so opposed to him in medical views. Another father, who also occupied an eminent place in our school, has a son practising in our school who does not in the least stick to the rules that governed himself. I infer from this that there are certain conditions of circumstance and mentality required to make a man capable of grasping the fullest meaning of homœopathics, and that the sire is in no sense a guarantee for the son.

Now, no one will say that a man has not the privilege to do as he pleases. He even has the privilege of being a physician first, and a homœopath afterwards; but the absurdity of the situation, seeing what is claimed for Homœopathy, is so apparent, that the course subjects the practitioner to the ridicule of men who respect law and her pretenders. We are soon to erect a memorial to Samuel Hahnemann. It is to be presumed that the man did something during his life that deserved perpetuation, and that our acknowledgment of that something takes the form of a bronze reproduction of the man himself. It is to be placed in the Mecca of American Liberty. People are to read in its outlines that a learned profession is so grateful for the discoveries of the man that it pays the highest possible tribute to him—places him before the world in the company of discoverers, statesmen and warriors.

Need I tell you what that *something* is? The *something* that specializes that man, that places him upon a pedestal before the world? Need I repeat the section after section that clearly

defines the wherefore of his greatness, that singles him out as the one person among the host of medical dignitaries that commands our monumental consideration ? If you say, *No!* then I conclude that this inanimate expression of your acceptance of his edicts is proof positive that he spake the *truth*. *Do you follow the lines professed?* If not, then does this monument bespeak, not the correctness of the enunciations of the man represented, but rather is it an embodiment of the vanity of the men who build it. But evolution, my boy, evolution, what changes it makes in everything ! No, it does not change everything. Men's habits, men's religions change ; but natural, eternal law, never. Kepler-Newton changes not, and if natural law is the basic principle of Homœopathy, it cannot change.

As said before, I am sorry that circumstances call for reintoning the old story. It is perhaps true that it is time and money wasted, that men's habits are fixed, not so much by the habits of other men as by the bent of their own desires. And after all, the element of tact and impressiveness plays so largely in the work of medical practice, that it matters very little whether intelligence is back of it or not. The greatest pretender has the greatest following. We often hear that what that doctor cannot do nobody can do, a verdict that generally comes from the lips least capable of expressing good judgment. It is good for the doctor, bad for the patient. It is infinite judgment of an eminently finite subject. Have you ever been made ashamed by hearing such expressions relative to yourself? or has your blood boiled when you heard some person say, "I would not allow Doctor So-and-So to attend a cat of mine?" Such things extenuate a deviation from the best methods when people are not capable of determining what are the best methods, and practice degenerates into the makeshift of money getting, and giving the patient what he is willing to pay for. The conscienceless man takes in the situation and shekels, but the other fellow who builds enduringly, who despises deception, whose monitor is truth, finds it difficult to smother the better part of his nature and sink to the plane of the mountebank.

Choose ye this day whom ye will follow.

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COLOQUINTH has violent gastralgia; cutting, sharp pains, which seem to centre in the pit of the stomach from other parts; ameliorated by hard pressure and bending double, though the spot may be sensitive to the touch.

## SCIENTIFIC MURDER OR KILLING BY KINDNESS.

BY W. S. SEARLE, M.D., M.A., BROOKLYN, N. Y.

(Read before the Homœopathic Medical Society, of Kings County, N. Y.)

ANY physician, who at this day should deny the value of the results of recent researches in bacteriology, would simply write himself down as unworthy of respect. I, at least would not decry such studies nor deprecate their continuance.

It is, however, in my opinion, unquestionable that much which some doctors unhesitatingly accept as proven and true in this branch of scientific study, both in theory and in the practical application of such theories is, as yet unproven and untrue, not only, but highly injurious instead of beneficent in practice.

Unless I greatly err in judgement, I have seen lives sacrificed on the altar of antisepsis that might have been spared had we not tried so hard, and so injudiciously to save them. I shall not soon forget nor ever fail to deplore the death of a lovely and robust young lady in the early days of our hospital experience. The late Doctor Varona removed from her abdomen a dermoid cyst of the ovary. It had a small pedicle and no adhesions, and there seemed to be no reason why she should not make a speedy and entire recovery. The room she occupied and all its contents had been disinfected till no germ dared show his nose there. The very greatest care was taken with ourselves and the instruments. But we could not be satisfied without a constant stream of carbolic spray over the abdomen till the last stitch was taken.

To our consternation, the patient promptly died on the third or fourth day. And if she was not killed by our microbe killers, I don't know why she died.

But this is somewhat aside from my purpose. I simply want to narrate a late experience which illustrates and enforces the old motto, "*festina lente*"—go slow—as well as that of Holy Writ, "prove all things." I might add, and wait till they are proven before adopting them in medical practice.

Probably nothing in all bacteriology is more certain than that

typhoid germs are sometimes conveyed in milk. That may be taken as proved. But this innocent looking white fluid, we all absorb with such gusto, has been lately suspected on this and other grounds, of being loaded with other germs. And this is, at least, questionable. Indeed, it begins to appear as if for some unknown reason, when deprived of the germs it carries in its bosom, it is also shorn of its value as a food. To this the following narrative seems to bear witness. A few weeks ago I was called to see a child of eighteen months. It was a very puny, emaciated, old looking atom—crying day and night, passing a dozen undigested stools a day. Since April last it had been fed exclusively on sterilized milk, prepared after the most approved scientific fashion, and it steadily declined life on these terms. If ever there was a scorbutic baby this was one. I ordered a change to ordinary milk, defying its microbes, and felt like Ajax defying the lightning. I gave it beef and orange juice and both baby and parents and I have held thanksgiving services every night since.

By one of those curious coincidences with which all physicians are familiar, I opened the current number of the *American Journal of Medical Sciences* the other day, and read therein an article by Dr. Starr, of Philadelphia, on same subject. He narrates six similar cases treated in the same way with like happy results.

Now what lesson may we learn from this experience? I can express my idea of it by paraphrasing Lincoln's celebrated political aphorism. You remember he said, "you can fool all of the people some of the time, and some of the people all of the time, but not all of the people all of the time." So here I would say you may profitably feed all babies on sterilized milk some of the time, and, perhaps, some of them all the time, but not all babies all of the time.

It may turn out, on longer experience, that the whole truth is even narrower than that, but this, I take it, is all we can fairly deduce from such limited trials as we have so far had.

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**COLCHICUM** is indicated in chronic and subacute pericarditis, with exudation of water in pericardium, with severe pain about heart; oppression and dyspnoea, as if chest were squeezed with a tight band; the heart action being weak and indistinct, pulse even threadlike; in some cases feeling of icy coldness at pit of stomach.

## SURGERY OF THE FACE.

BY R. W. McCLELLAND, M.D., PITTSBURG, PA.

(Read before the Homeopathic Medical Society of the State of Pennsylvania.)

I WOULD like to call the attention of the Society to a class of cases that are always very much in evidence—namely, certain injuries and deformities of the face. We are apt to overlook the fact that much of the happiness or peace of mind of an individual may depend upon approximately correct facial outlines. Any distortion of the God-like image, whether from accident or a failure on the part of that whimsical old lady, Dame Nature, to properly finish up the work, is apt to have depressing effects. The victim of bungling face surgery or of Dame Nature's lapses is oft-times a repulsive and unsightly object, a fact appreciated by no one more keenly than the sensitive subject himself. Hence, let us look carefully after this numerous class of cases and not be content with mending the cut or gash with adhesive plaster, or perhaps choking it up with vaseline and covering with a bandage. This is the lazy man's expedient and an abomination in surgery.

I am sorry to say I have seen such work coming from the hands of physicians who ought to have known better. It matters not how deep or long the gash, if the tissues have not been lacerated or devitalized to too great an extent, good union is sure to follow in from 3 to 4 days, if simple precautions are observed. It has been my fortune to see an unusual number of these cases in the past year. In their management the plan which I have found invariably successful is to wash out the wound carefully with a 5 per cent. carbolic solution to which has been added a small quantity of succus calendula. Care is taken to handle the parts as little as possible, at the same time making sure that all foreign matter is removed, together with any shreds of tissue. Coaptation is made as perfect as possible by means of fine silk ligatures. There is no advantage in the use of catgut, as it is more bulky and must be removed the same as the silk, on the third day, if unsightly stitch-marks would be avoided. The sutures are to have a good subcuta-

neous hold, and must be brought out close to the skin margins, but not so close as to make them liable to cut through. For the same reason they must not be drawn too tightly, for the ensuing swelling, especially in some locations, would be sure to cause a cutting through. They are not to be left in too long; 2 or 3 days is sufficient if subsequent care is taken. On the other hand, this will depend somewhat upon location. If the wound is a deep one, in the region of strong muscular action, the sutures must be left in position for a longer period and the parts subsequently supported by firm retaining straps. I recall a case in point which demonstrates the necessity for observing these precautions. A client of ours, a young lady, while on a visit to Philadelphia, received a severe gash on the side of the face with a piece of glass. A prominent old-school surgeon was summoned and skillfully dressed the wound. The sutures were removed early to avoid marking, but straps were not used. For the first week or two the suture-line was thin and hardly noticeable. But from the powerful action of the masseter and other muscles concerned in mastication the scar widened and became elevated and inflamed, producing a most unsightly and repulsive appearance. Surgeons east and west were consulted, but all hesitated to attempt a remedial operation. I will conclude by saying that the surgeon who operated originally succeeded in almost completely obliterating the scar by the internal administration of thyroidine.

It would be superfluous in this day of ultra-asepticism, to say that in every case absolute cleanliness must be observed in addition to our use of antiseptics. And yet it was my experience while serving for several weeks in one of the Berlin hospitals, to observe the practice of this absurd contradiction. The visiting surgeon was very particular in the employment of antiseptics but he would pick up a piece of gauze and trail it over septic surfaces or use ligatures that had dropped or come in contact with the clothing of assistants. This mistake is much more frequently made in those minor operations of private practice and operates largely in preventing good or perfect results. In the final dressing of a wound, a little europhen, which is much superior to aristol for this purpose, is dusted over the surface and a compress of borated gauze held in position by strips of adhesive plaster. If the europhen is applied unevenly and in

too thick a layer, the result will be unsatisfactory, for the pressure of the compress will depress an edge of the wound, destroying the line of union at that point. This is a small matter but one which counts in wounds of the face. In an experience covering some hundred odd cases where these precautions were observed, I have yet to note one in which immediate union did not take place. In hare-lip cases I would call attention to a few points which I have found useful. First to make the flaps of sufficient width, they should involve the whole thickness of the lip, and come well out to the skin margin. Second, the lip should be well dissected off from the gums with a pair of curved scissors. Loops of thread introduced on each side are useful here, in controlling hæmorrhage from the coronary arteries.

The notch so frequently seen after this operation may be avoided in large part by saving a portion of the flap on one side and carrying it across, thereby securing an even line. Malgaigne's device is similar to this and much used at present. A flap is brought forward from each side and united, making a finger-like projection which retracts in the process of healing. I think the former method secures a much smoother result. Silk worm ligature is superseding the use of catgut, which is unreliable, and hare-lip pins are no longer in favor. However, as against the puncture marks of the pins, we have the advantage of securing a better and flatter surface by their use. I still use the pins but avoid the marking by withdrawing on the second day, leaving the figure-of-8 sutures in place which retain the parts very nicely. Some time ago an odd case presented itself at the hospital; a case of double nose or more properly two distinct noses separated by a deep sulcus which was very much ridged, the ridges extending well up on the forehead.

The inner surface of each structure was removed with all the rugous tissue, and the parts brought together by means of sutures and harelip-pins. Perfect union ensued, and the child, a babe of 6 months, was discharged on the fourth day. I am sorry, gentlemen, that I have not this case to present, as I had hoped, the family living at a distance from the city. I will cite here also a case of marked deflection of the nose. The young lady in question was thrown from a swing, with the result that the bony structures of the nose were broken down, and this use-

ful member deflected from the normal perpendicular to the extent of about an inch and a quarter at the tip.

There had been, since this accident, more than a year ago, complete stenosis of both nostrils. My *confrère*, Dr. Blair, relieved the stenosis on one side by the electro-cautery. I then operated by means of the septum punch and forceps, by which the normal position of the parts was restored. Pledgets of cotton and gauze, saturated with a solution of permanganate of potash, kept the nostrils patulous, while a strip of adhesive plaster drew the nose round into position, an over-effect being produced to secure more perfect results.

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## OPERATIVE SURGERY.

BY CHARLES LESLIE RUMSEY, A.M., M.D., BALTIMORE, MD.

ONE hundred laparotomies without a death would be an encouraging title, but it may not advance our knowledge of surgical pathology. An analysis of a single death from hæmorrhage, peritonitis, suppuration, mistaken abdominal tumor or even an unwarrantable abdominal section proves of value. It is not the province of this paper to record cases, to reflect glory upon the operating surgeon and his associates. Such cases have been selected from the surgical wards in "The Maryland Homœopathic Hospital" for publication, as will be most useful from their pathological significance or their uniqueness of character. To these cases the writer has appended conclusions based solely upon clinical experience. It is hoped this will add to the value of the paper.

In the writer's surgical work at the hospital, three deaths are recorded, which are here published. The technique of aseptic and antiseptic surgery has been so thoroughly discussed that it is only necessary to add that the precaution was taken to make use of each new discovery. It is difficult to secure perfect asepsis in any general hospital. The assistants and operating-room must, at times, be employed upon septic as well as clean cases.

CASE I.—G. C. White, male, æt. 21. Admitted April 3, 1894. Patient had been operated upon "six times, and anæs-

thetized eight times," at a well-known hospital in Baltimore, for necrosis of the right humerus. The scar tissue would be in length greater than the arm. Patient was a farm hand, and incapacitated for physical labor for two years. His ear had been discharging for an indefinite time. On admission to the hospital, the auditory canal was moist. Otherwise, the patient's general health was fair. On examination with the probe, denuded bone was detected, and on April 4th operation for necrosis of the humerus was performed. As nature had performed her part in separating the living from the dead bone, the sinuses of the soft parts were opened freely to thoroughly expose the cloacæ in the healthy bone. The smooth cavity, out of which the dead fragments had been extracted, was plugged with iodoform gauze. In forty-eight hours the wound was perfectly dry, no blood clots, etc., and healing was allowed to take place from the bottom. *Silicea 6x* was prescribed, and medication continued till November, 1894. The sinuses healed perfectly in six weeks. Patient made a speedy recovery, with "no tem perature nor pain." In February, 1895, patient returned to have a "pterygium" removed, and related the following story to the senior class in the "Southern Homœopathic Medical College:" "I slipped on an icy walk in Patterson Park during Christmas week and broke my right arm. The patrol took me to the neighboring hospital, where several operations were performed previous to the one performed here. The surgeons of the hospital remembered me, and thought it was remarkable the arm had healed and united after the fracture. They ascribed the better results to the fresh air! I was afraid to tell them where I was cured." The result may be attributed to *silicea*, which confirms the efficacy of our remedies in surgery as well as to "the other ills to which human flesh is heir."

CASE II.—J. M., white, male, æt. 57. Admitted April 18, 1894. There was a history of haemorrhage from the bladder for an indefinite time. There was seldom any marked obstruction in the urinary flow, but shreds or growth were described "to come away without difficulty." During the six months previous to J. M.'s admission to the hospital, the haemorrhages were of greater frequency and more severe. The pelvic glands were not enlarged, nor could pelvic indurations be detected. There was a sensation of pressure to actual pain in the loins. On exploring the bladder, a resistance was noted to the right portion, which occasioned a severe haemorrhage. On examination of the urine, there was trace of albumin, blood corpuscles, and epithelium. A two-inch suprapubic incision was made. The bladder was distended, and a one-inch incision was made into the bladder-wall. Two hooks were then inserted on each side of the knife, while in the bladder, by

which the wound was held taut. Light was reflected by a head mirror upon the papillomatous growths, which were removed. Haemorrhage was checked by firm pressure of aseptic sponges, previously wrung out of boiling water, against the surface of the affected viscus. The bladder was then irrigated with a warm boracic acid solution. Blood-clots were taken out of the bladder. There was much bruising of tissue, and patient died of peritonitis.

In an experience of five lithotomies, one exploratory incision (tubercular cystitis), the extirpation of one benign tumor,\* and observation of many more, it is believed bladder surgery should be controlled by the condition of the wall of the bladder, as felt through the rectum or vagina, and the degree of cystitis. Although papillomata are innocent tumors, as time advances, a papilloma may undergo carcinomatous degeneration towards its base, and rapidly take on malignant action; this is a sufficient argument for their early ablation. The sarcomata infiltrate rapidly, for they originate in the submucous tissues, and part or all of the bladder is soon transformed into a thick, hard cake. If it should be pedicled, as was seen in one case, it must be mixed with some definite tumor, and can be successfully removed.

In cavernomata, two well-pronounced types are found, between which are many intermediate grades. This is of the utmost importance in giving an opinion as to the advisability of dealing with this malignant tumor. One develops very slowly, infiltrates indolently, and its activity increases towards the surface; the other variety is dense, rapidly infiltrating with that peculiar cakelike hardness, which a novice could readily detect by rectal examination. The former, by some authors, should be extirpated. This judgment may be questioned, as no case has been observed to recover. The continual passing of forceps, curettes, and sponges, through the wound and bladder incision, can be rendered unnecessary by the introduction of the "caisson" used by Dr. Fenwick. All bruising and tearing of the bladder incision by these manipulations can thus be avoided. If cystitis is present, all chances, says Dr. Fenwick, "of fouling of the perivesical tissue is minimized." The "caisson" can be shifted from place to place to detect primary

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\* The only fatal case.

or secondary growth. In a post-mortem examination there was a septic peritonitis caused by the infiltration of urine.

**CASE III.**—J. B., colored male, æt. 18. Admitted August 21, 1894. In a quarrel with a comrade, a pistol was shot about two yards directly in front of patient who was, also, kicked in the abdomen. There was no shock and patient had a wound directly between and one inch above the eye-brows. The wound was probed and no ball detected. At this time, it was thought inexpedient to make incision to see if ball was imbedded in the vertical portion of the frontal bone. There was acute conjunctivitis from explosion of the pistol and traumatic peritonitis from the "kick." The temperature ranged from 99.4° to 101.4° and the pulse from 110 to 120. No further exploratory incision for ball was made as no symptoms were manifested. The eye conditions yielded to a boracic acid solution (grs. xv., ad 3*j.*) applied as a wash every three hours. A linseed-meal poultice, for the abdomen was renewed every two hours. *Arnica* 3*x*, was prescribed which was changed to *bryonia* 2*x*. The patient made an uneventful recovery.

In this connection may be mentioned, a case of traumatic peritonitis which became purulent. It was not till the patient's life was fast ebbing away that an abdominal section was made. Adhesions were formed everywhere and the peritonæum was covered here and there with a pyogenic membrane. The patient died two days after the operation. Had the abdominal section been made earlier, the prognosis, it is believed, would have been favorable. The use of purgatives followed, if necessary, by enemata is indicated in such cases. Surgical interference should be kept in mind, if the measures used do not act quickly. It may be said that in all cases of suppurative peritonitis, the washing out of the peritonæum gives the patient a chance for life.

**CASE IV.**—Colored, male, æt. 53. Admitted September 6, 1894. Patient was a hod-carrier. He had a large complete, oblique inguinal hernia. A Bassim's operation was performed. With regard to the method calculated to secure a permanent cure, that is advised which will secure obliteration of the neck of the sac, within the internal ring; separation of the cord from the sac; the removal or ligature of all the veins of the cord, except one or two (it was found to produce atrophy of the testicle in another case); the formation of a new channel for the vas deferens; the obliteration of

the inguinal canal by approximation, layer to layer, of its incised margins; and lastly, the careful suture of the superficial structure. Kangaroo tendon was used to suture Poupart's ligament, and the conjoined tendon, in this case which is preferred. Primary union is more favorable to a permanent cure than granulation. With the experience of six radical cures for hernia, without one recurrence, the writer might recommend a radical operation.

In five cases, primary union took place. In one case, a female patient in the surgical wards, with a complete inguinal labial hernia, had the dressings removed the twelfth day and the stitches removed. At the most inferior end of the incision, the wound gaped, which was easily brought together by adhesive straps. On removal of straps, three days later, there was some pus in the wound. Bovinine was used. Peroxide of hydrogen proved more effectual. The patient should not be allowed to sit up for fifteen days, nor resume his daily toil for ten weeks. If his occupation is laborious, the time should be extended. The wearing of a truss, as a precautionary measure, for at least six months is recommended. The disability of mankind from this cause is appalling. Not that every individual who has hernia is totally disabled, but that each person so afflicted is partially unfitted for manual labor. Therefore, the sum total of loss to the active industry of the country is considerable. This is undoubtedly true where a hernia is irreducible, or where a truss fails to retain the hernia, or, where strangulation has occurred—in the latter case, an attempt at radical cure should be made—surgical interference is demanded. Reference may here be made to Bank's Report in the *British Medical Journal*, for November, 11, 1893. Let attention be called to two important facts: First, removal of omentum in hernia operations. Dr. Bull, of New York, mentions cases of inflammation of an omental stump, abscess occurring three months after the operation, and peritonitis starting from the stump. The doctor also mentions the well-known accident of haemorrhage due to slipping of ligature (*Annals of Surgery*, March, 1893). Second, in regard to gangrenous hernia—through various surgical writers, it has been found that artificial anus or colotomy has a greater fatality than immediate resection and suturing. McCready's *Treatise on Ruptures*, one of the

ablest works published, says: "We can only speak of the probabilities—it may be said, that many boys are cured, but then the prospect is more favorable for girls; the younger the patient the more favorable the case." The value of Dr. McCready's work can be estimated when he attributes many of his conclusions to the London Truss Society—the largest hernia clinic in the world. It may be added, children are known to have been cured by the truss alone.

CASE V.—J. M., colored male, æt. 25. Admitted September 21, 1894. Patient was shot in abdomen and brought to the hospital with undershirt and shirt well saturated with blood. The ball was located in the left rectus abdominis muscle and under the floating rib by my colleague and then interne, Dr. Hendrix, and extracted. The entrance was above the right crest illium. As the patient was suffering from a shock too severe to relieve an internal haemorrhage diagnosed, the remainder of the night was passed at the hospital to perform an abdominal section as soon as it was justifiable. Hypodermics of whisky were administered and saline solutions injected into the rectum. *Veratum alb.* 3x, was prescribed. One hypodermic injection of morphia (gr.  $\frac{1}{4}$ ) was given for intense suffering. Patient died in about five hours. A post-mortem revealed perforation of the stomach and small intestine. The peritoneal cavity was filled with clotted blood.

In the *University Medical Magazine*, September, 1893, Dr. Lippincott has brought together some valuable statistics in favor of a conservative course of treatment in these injuries. His conclusions are as follows: *First*, in about 90 per cent. of the penetrating wounds of the abdomen, the viscera are involved. *Second*, in the majority of cases of abdominal gun-shot wounds, the intestinal lesions are multiple. *Third*, wounds of the stomach and small intestines are more grave than those of the large intestines. *Fourth*, shock itself is not a symptom of internal haemorrhage. *Fifth*, the use of hydrogen gas by rectum as a means of diagnosis is not infallible. *Sixth*, nature is capable of effecting complete repair in wounds of the viscera by prolapse of the mucous membrane, exudation of plastic lymph, bringing the healthy surface over the rent in gut and finally cicatrization. *Seventh*, laparotomy has increased the mortality of gun-shot wounds of the abdomen and is not justifiable except in well selected cases and particularly where there is internal haemorrhage.

The following conclusions may be added from a varied hospital experience and study of such cases. As soon as you diagnose visceral lesions complicated with abdominal injuries, prompt surgical interference is demanded. In cases of complete rupture of the intestines or of severe injury necessitating resection, enterorrhaphy with drainage would be the best plan of treatment. The large intestine is rarely injured on account of its protected position. If the stomach should be perforated, the rent should be sewed by Lembert's suture. In laceration of the liver, the surgeon should have recourse to suturing or to plugging. In laceration of the spleen, the haemorrhage will often be so profuse as to compel the surgeon to perform splenectomy. The contra-indications are intense nervous shock immediately following the injury and at a later stage, the patient, from severe peritonitis, is cold and cyanosed. In short to promote reaction and control haemorrhage, stimulate hypodermatically. In such cases never administer anything for the first few days through the mouth.

CASE VI.—H. A., white male, æt. 8. Admitted October 11, 1894. History of patient was indefinite. Both parents were extremely nervous. The mother had miscarriages before the birth of this patient. The mother was frightened at thunder storms, and suddenly died. It was assured by the grandmother there was no difficulty at this labor. The case presented the following clinical features: fingers stiff and awkward, with a constant slow motion of the arms, particularly the left one (athetosis); a double paraplegia, with legs stiff and closely adducted, and so helpless that walking was impossible; electrical reactions were not qualitatively changed, and the sensation normal. There was slight convergent strabismus, with a partial atrophic condition of the optic nerve. The pupils responded feebly to light, but not to accommodation. There seems to be a depression over the occipital lobe due to deficient development to which the symptoms of partial blindness may be attributed. The tuning-fork was perceived; to what extent it was impossible to estimate. The arch of the palate was high, with a marked defect in the development of the forepart of the head. There appeared to be a very early union in the coronal and sagittal suture. At times it was thought a depression existed in the skull over this locality. The shape of the head was elongated like that of a new born babe. One might believe it was due to the constant laying of the head in one position. The child never showed any intelligence whatsoever; never

walked nor talked, nor fed itself, and its person was attended to as in the case of a baby. Bowels were either diarrhoeic or constipated. There was nothing about the delivery sufficiently unusual to awaken the suspicion of trauma. This is of clinical value, as cerebral haemorrhage, particularly meningeal, may be the cause of the symptoms. In this case an intra-uterine encephalitis or some unknown cause had prevented the foetal brain from developing. On more than one occasion cerebral localization was attempted. The family consented to "craniotomy." On November 17, 1894, a strip of bone on the right side was excised, three centimetres in width, extending from the line of growth of hair in front to near the occipital protuberance. The trephine was applied first, which allowed a starting point for the metacarpal saw. The periosteum was sewed by fine catgut, and the wound was closed without drainage. There were stitch abscesses. Owing to the extreme weakness of patient, the operation was attended by a severe shock. About six hypodermics of whiskey were given. *Camphor* 2x, followed by *digitalis* 1x, and later *calc. phos.* 2x, were the remedies prescribed. Temperature was not above 99.8°. The pulse was weak and averaged 90. After this "craniectomy" patient swallowed very well, and laid quietly in bed. The night cries had stopped, and the strabismus convergens was notably diminished. From the night preceding the operation to the beginning of January, 1895, no anodyne was given, when there was a return of the convulsive movements and cries. On January 19th, a similar operation was performed on the other side of the head. To hasten the craniectomy, a circular saw, three-quarters of an inch in diameter, attached at right angles to a rod two and one-half inches long, suitable for a dental engine attachment, was devised. The patient suffered less from shock. There was little or no benefit from this operation. Patient died October 4, 1895, from exhaustion.

Post-mortem revealed no special features. The cerebral substance did not completely fill the superior part of the cranial cavity. The head measured the same in its various diameters after the craniectomy as before. The brain was immediately put in Müller's fluid for microscopical examination, which prevented securing the weight.

In studying the literature on this subject, from the first craniectomy by Dr. Fuller, of Montreal, in 1878, to the statistics of to-day, there seems a great diversity of opinion by operating surgeons. A brief summary of Keen's, Jacobi's and Victor Horsley's experiences will be profitable.

Keen reports eleven cases operated upon; seven survived,

four died. Of the seven survivors, one showed no improvement; in five, there was a "moderate and slow improvement;" and in one the improvement was a "little more marked." Keen summed up his views as follows! "In the case of a microcephalic idiot, I shall certainly be willing to operate. I shall explain to the parents about one in four dies. That if the child survives, there may be no improvement whatever, but the probabilities are there will be moderate improvement. Jacobi denounces craniectomy in no measured terms. Victor Horsley performed two operations in the presence of the writer; one patient died on the third day; the other was much benefited. He is a strong advocate of the operation. In view of the hopelessness of the condition, and the chance of improvement, Dr. Horsley believes craniectomy should "be carried out in all cases." It may be noted a majority of surgeons do not approve of the operation after the patient has passed eight years of age. Binnie, in a thoughtful paper (*Annals of Surgery*, April, 1894), advocates craniectomy in "simple mal-development of the brain, producing imbecility, as likely to remove a something which has hindered development or prevented action of some parts of the brain already more or less developed." However this may be there is no doubt that beneficial results have been obtained by cranial operations in cases of traumatic, epileptic and paralytic idiocy, but operating must not be delayed until serious atrophic changes take place.

CASE VII.—T. S., colored male, æt. 15. Admitted December 3, 1894. Patient has cough, profuse epistaxis, hectic condition, apex of left lung suspiciously dull on percussion. Two sinuses in left chest wall from which there is a discharge of pus. Anorexia, diarrhoea, slight scoliosis. The knee-joint was swollen, painful, exquisitely sensitive to touch. The leg was flexed on the thigh and the thigh on the abdomen with abduction. On December 4th, patient was anaesthetized with chloroform. An ethereal solution of iodoform was injected into the knee-joint. The leg straightened on a posterior knee-splint. Though the roughened body of the left sixth rib was detected by a probe, the sinuses were simply syringed with peroxide of hydrogen and dressed aseptically. *Silicea* 6x, and later *calcarea fluoricum* 6x were prescribed. Within twenty-four hours, the temperature became normal and the pain very much lessened in the joint. On December 11th, "the old pain and sensitiveness" returned, when another ethereal iodoform injection was made

into knee-joint. Improvement was rapid and continuous. In four weeks, a plaster-of-Paris cast was substituted for the posterior straight splint and patient allowed to secure fresh air. In six weeks the plaster-of-Paris cast was removed and passive motion made. The assimilative powers were constantly strengthened by nutritious diet as milk and eggs.

The conservative treatment for tubercular arthritis or ostitis has invariably yielded the writer most excellent results. Atrophy of the muscles has been invariably noted and regarded as a characteristic of a tubercular joint. It affects certain muscles and groups of muscles. In the hip, the gluteals are affected: in the knee, the quadriceps extensor; in the ankle, the extensors; in the shoulder, the scapular muscles; in the elbow, the triceps and biceps; in the wrist, the muscles arising from the internal condyle of the humerus. There is recommended another diagnostic aid. Seat the patient on a table with legs hanging down. Induce the patient to swing the extremity with a lateral motion and note the arc described by the diseased limb; it is less than by the other. Its purpose is to study the slight difference in muscular reaction and to recognize the repugnance of the muscles to relaxation caused by their spasmoidic action. In adopting the conservative measure, treatment has yielded better satisfaction with the injection than without. Preference is given to iodoform and ether than to other iodoform emulsions whose clinical value has been tested. In one case, a female, æt. 12 years, all the caseous detritus was removed by careful curetting. The cavity was filled with a boiling salt solution (3j ad Oj). The cavity was emptied and refilled until a sufficient degree of cauterization was effected. The results were not so excellent as by iodoform emulsion. In regard to excision, it seems better surgery to prolong conservative measures. *Homeopathic remedies*, injection, joint fixed and protected against jar and concussion until the child is twelve years of age, particularly, if it is the hip-joint. This rule, of course, bends if the patient's life is threatened. This suggestion is based on clinical observation as the writer has performed but two excisions, both of which were hip-joints. One patient was nine years old and died. The other was sixteen and made a good recovery. Amputation, of course, is the last resort.

CASE VIII.—E. L., white female, æt. 5, 602 P. Alley. Pa.

tient had diphtheritic croup. From the history, the membrane evidently extended from the pharynx to the larynx. There was marked dyspnoea and the pulse was slow and strong. Intubation was successfully performed on February 7, 1895. One who has acquired manual dexterity in laryngoscopic examination and has an anatomical knowledge of the living larynx and trachea, can soon possess the requisite skill for intubation. It requires practice. The technique will be found described in the text-books. Artificial light and the head-mirror are used. The concavity of the handle of a spoon bent at right angles to the bowl, is so inserted as to push the tongue forward and prevents its ascent to the roof of the mouth. The intubation tube is carried close to the base of the tongue when your left index finger is substituted for the spoon. Let the spoon drop into the patient's lap. The patient has given a cough, in cases intubated, which raised the epiglottis. When possible hold the epiglottis in this position with the tip of the index finger. This is very difficult and it was found to be more often unsuccessful than successful. As soon as the patient coughs you may be able to insert the tube without feeling the epiglottis. The practice should be frequent rather than prolonged. This patient was successfully fed by having the head lower than the body in the mother's lap and a little to one side.

In one case a catheter through the nasal passages into the œsophagus was satisfactorily used. These cases require constant attendance and was visited as often as four times the first twenty-four hours.

Let me relate the experience of five tracheotomies : (a) Adult, sarcoma of the larynx which caused great displacement of the larynx and surrounding tissues. (b) œdema of the mucous membrane of the larynx, fourth day after confinement. (c) Case X. (d) Diphtheritic croup, æt. 7, died. (e) Diphtheritic croup, æt. 12; and four cases of intubation.

Stenosis of the larynx from scar-tissue caused by an unsuccessful attempt to commit suicide, which tracheotomy had been previously performed three intubations for diphtheria and no deaths—the ages were 2 years, 5 years, 8 years. With the patient æt. 8, the introduction of the tube detached and pushed the membrane into the trachea—it was too large to be expelled and a tracheotomy (low operation) was successfully performed. There was haemorrhage and by the time the tube was inserted into the trachea, which at first became insinuated between the trachea and tough membrane, breathing had ceased; artificial

respiration restored the patient, who made an uneventful recovery. In the first set of cases, the death recorded was that of male, æt. 7. There was haemorrhage. It was not checked before inserting the tube, on account of the patient's condition and with the hope it would cease on respiration. The blood found its way into the lungs which were partially asphyxiated by chloroform. There was respiration through the tracheotomy tube some five minutes.

The following facts are observed :

*First.*—The superiority of the *high operation*. In every "low operation" performed, the inferior thyroid, or thyroidinia, usually both, have been severed. In children, where the neck is short and stout, is it not more good fortune than good management when this haemorrhage is prevented in the low operation?

*Second.*—Four per cent. injection of cocaine on the territory of the operation is much preferable to anaesthetics.

*Third.*—When the hook, placed in the cricoid cartilage, is held tense, suffocation can occur. Allow always for respiration.

*Fourth.*—The period at which the tube can be removed is arbitrary; it is permanently removed as soon as the patient is able to breathe through the larynx. This knowledge is secured by temporarily closing the wound in the trachea by gently bringing the wound-edges together. The latter is done by sterilized gauze on each side of the wound. Tracheitis is not very uncommon.

*Fifth.*—A rule is made to cleanse the inner tube every hour during the first twenty-four hours. If the secretions are dry and cling to it, they are best removed by solutions of soda bicarbonate (gr. x. to aqua  $\frac{3}{4}$ ). Sponging and brushing out the trachea is unwise, unless the exudation cannot be brought up by cough or feather.

*Sixth.*—If an anaesthetic is not used, the arms should be held by an assistant; this is better than securing them by a binder around the chest, which embarrasses respiratory movements.

*Seventh.*—In every case, hospital and private practice, the evidence derived from physical exploration was *nihil* to determine membranous extension.

*Eighth.*—It has been thought, at times, increased frequency of pulse denoted extension of the membrane. After the study

of many cases, this is regarded as unreliable. It may be due to the stimulation to which most physicians resort.

*Ninth.*—Medical interference can exhaust a child.

*Tenth.*—The value of capable assistants to hold the head *steady*, another to hold the retractors *steady*, placed by the operator, cannot be overestimated.

The retrocession of the supra-sternal notch, suppression of voice, and cyanosis, are the most reliable symptoms to indicate rapid extension into the lower air-passages.

*As a last resort*, the knife should not be discouraged, if there is reason to believe that death is threatened simply by obstructive causes. The importance of early operative interference should be urged. If a case continues about the same, or, alternately becomes better and worse, operative interference is demanded. Such cases have been observed by physicians to recover; but, the risk of the last resort is much more unfavorable than an early operation. In comparing intubation with tracheotomy, the disadvantages are: *First*, intubation does not afford such good drainage for the trachea. *Second*, only a limited amount of nourishment can be taken by the intubated patient. *Third*, accidents are more common in intubating, as pushing the membrane into the trachea. Any one who has made post-mortem examination of a diphtheritic throat, can understand the ease with which this is done, though comparatively few cases are reported. One would think intubation is contra-indicated where there is "a flopping" of membrane. The cord is invariably left attached to the tube. While this is hard on the patient, its removal is easier, and with less risk to the patient. As a rule, the younger the patient the longer will the intubating tube be required.

**CASE IX.**—O. A. M.,\* white male, *æt.* 62. Admitted February 20, 1895. Patient had been suffering from facial eczema. There was a growth to the inner side and just below the left malar bone. It had increased its growth in six months from a hickory nut to the size of a walnut. It was hard, nodulated, confined to the superficial integument with skin adherent to growth. On February 21st, the tumor was extirpated even to healthy tissue surrounding the growth. A plastic opera-

\* October, 1895. Slight induration one-half inch above original seat. Treatment, *streptococcus erysipelatis*.

tion was performed. Temperature remained normal, with healing by first intention. *Arsen. alb.* 2x was prescribed. A microscopical examination of the growth revealed melanotic sarcoma. The periphery of this growth was also examined by the microscope to find typical tissue.

Dr. Robinson, of the New York Cancer Hospital, believes in the removal of non-malignant tumors by excision. As there is no limiting membrane, no definite guide to the extent of inflation, he believes malignant growths are best treated without the knife. We will not discuss at this time the relative merits of operations by cutting instruments, electricity, curetting, combined curetting and caustics. It is believed certain caustics, judiciously and properly applied, are of undoubted value. Caustic potash is useful in small tumors situated upon the forehead, cheek, lips. It ought not to be used near the eyes nor upon the alæ of the nose, nor where the tumor is near an important vessel. There is an objection to caustic potash inasmuch as it destroys pathological and normal tissue about equally. Chloride of zinc is less rapid in its effect than caustic potash, but causes greater pain for a long period. With arsenious acid in the form of Marsden's paste, the writer has seen the best results. It is not suited to cancer of the lip or of mucous membranes on account of the danger of poisoning by absorption. Within twenty-four hours there is no danger of the acid destroying the surrounding normal skin. It is wise to allow this application to remain sixteen hours, and to lengthen the time as it seems best. Marsden's paste has much more elective action on the pathological tissue than chloride of zinc or caustic potash. If the epidermis is unbroken, it may be well to partly destroy it by using caustic potash to secure the prompt action of Marsden's paste. It has been noted that electricity can be regulated with more nicety, and is not so painful as caustics, and the cicatrix left is better. Two needles are employed, and a current with a strength of two hundred to four hundred "Milliamperes." The caustic action of both poles was freely used, and the current constantly alternated with a hand commutator. Kaposi, whose experience with sarcomatosis cutis is very extended, establishes a distinction between the multiple idiopathic pigmentary sarcomata (Kaposi's type), the ordinary melanotic sarcoma and the unpigmented multiple sarcomata of

the skin. This well-known dermatologist claims the latter form only is amenable to arsenical treatment, and advises extirpation by the knife for other cases. It is observed these applications seem to be suitable for lesions in certain stages, on the face, where the effects must be carefully weighed, and where plastic operations seem inexpedient. This mode of treatment is particularly recommended for rodent ulcer, and the Marsden's paste has given satisfaction.

CASE X.—W. S., white male, æt. 61. Admitted March 12, 1895. Patient had osteo-sarcoma situated at the symphysis of the lower jaw and involving the floor of the mouth. Pain was a dull aching character and the lymphatic glands were not markedly involved. From a laryngoscopic examination, it was ascertained the internal structure of the larynx was not affected. With the consent of the patient, it was determined to remove the whole growth if the external tissues of the larynx were not encroached upon. It was thought the growth was endosteal osteo-sarcoma which springs from the medulla in the interior of the bone and is less malignant than the periosteal variety which springs from the deep layers of the periosteum involving the bone and the surrounding tissues.

The tongue was prevented from falling back of the mouth by a ligature passed through its tip. An incision was made over the symphysis menti, preserving the orbicularis oris muscle. This incision was continued along the floor of the mouth. By the chain-saw, the diseased portion of the body of the inferior maxillary including the symphysis and one inch on each side of it was excised. The diseased soft structures were removed which were attached to the bone. Stenson's duct, all the nerves and the principal vessels were successfully avoided. The muscles of the tongue were preserved. At the conclusion of the operation there was asphyxia. The pushing forward of the tongue seemed to relieve the patient for a moment. It was occasioned by blood in the larynx and a tracheotomy was performed. The patient had an irritating cough for some days. The bones were not wired together as the operation proved a formidable one and it was the purpose to substitute the resected parts after healing of the wound. The incision of the chin united by primary union. On each side of the floor of the mouth an incision was made to allow the primary union to be approximated.

The floor of the mouth was irrigated with peroxide of hydrogen. (See treatment of tracheotomy. Case VIII.). *Arsenicum 2x*, was given internally. In the beginning of June the growth on the floor of the mouth began to return and erysipelas

cocci was obtained for treatment. The patient sought counsel at another hospital.

In writing this article, it has been learned from the patient's wife that "everything has been tried. They are now injecting something but it has done him no good. He cannot now swallow and is a mere skeleton, and can't last long." An identical case, whose condition did not allow the surgeon a knife, had the same termination. From a clinical study of these cases and others, the prognosis of a subperiosteal sarcoma is better without the surgeon's knife. The relief is only temporary. In such operations a preliminary tracheotomy is regarded preferable to the use of the tampon of Trendelenburg. With a sponge allowed in the lower pharynx, entrance of blood into the trachea with the "irritating cough" can be prevented. Anæsthetizing can go through the tracheal tube for the advantage of the surgeon. With such procedures, rectal alimentation would be necessary for several days. The value of immediate prothesis to be worn during healing process is evident. With a poor patient it is less expense to have one after cicatricial contraction.

CASE XI.—M. S., white, female, æt. 44. Admitted July, 1895. Patient came from another hospital, where she had been for eighteen months. During the previous six months, her general condition was much worse. M. S. had been in poor health for eleven years—had not menstruated for four years. On admission, the thyroid gland was very much enlarged. The breathing was rasping and whistling in character with hoarseness. There was throbbing of vessels in the body, particularly in the head. Hands and feet began to increase in size the year before, until all the classical symptoms of acromegaly, as described by Marie, were recognized. There was a mitral regurgitation, eyes pained patient, and there were noises in the ears. The ophthalmoscope revealed a marked pulsation of retinal arteries, while an aural examination showed no cause for the noises, which were attributed to the disturbances in the vascular system. *Spongia* 6x was prescribed with no benefit. The prescription, *bromine* 30x, was accompanied by marked amelioration of symptoms. Desiccated sheep-thyroids—six grains of which represent an entire average gland—had been received, and it was determined to give two grains three times daily.\* The

\* This prescription has benefited a patient upon whom a partial excision was performed, with *lycopus vir.*

patient was induced to live with a sister, the remainder of her days, which prevented a trial of this new preparation.

It was not heredity or inter-marriage which had to do with the ætiology. It is believed the general cause of this condition was a vaso-trophic neurosis. Many times operative interference seemed necessary. When needed, Jaloulay, of Lyons, treatment should have the preference. It is to make an incision into the capsule and expose the parts to the air. A case is recalled where this operation was performed by Dr. von Eiselberg, which relieved the dyspncea and dysphonias. This case had, undoubtedly, assumed a malignant type—diagnosis, sarcoma of thyroid gland, and general condition prevented the use of the knife. Eiselberg states the operation is only suitable for cases in which the growth is surrounded by a marked venous network, as it was in this case. Does this not indicate trophic influences? Dr. W. H. Thompson (*New York Med. Jour.*, March 25, 1893), considers this disease due to a lesion involving the common nucleus of the glosso-pharyngeal vagus and spinal accessory nerves extending to the neighboring vaso-motor centre in the medulla. In an operation upon the thyroid gland there is difficulty in freeing the tumor from the capsule which binds the organ down. Incisions may be made avoiding veins which are often large.

CASE XIII.—H. H. H., white male, æt. 11. Admitted July 11, 1895. The mother stated that when the boy was at home he passed gravel at irregular intervals with paroxysms of pain. There was pain at the end of the penis, frequent micturition. Physical exercise and jarring of body would increase the pain referable to the bladder and both ureters, and the patient was incapacitated to perform his duties at school. On examination of urine there was found uric acid, muco-pus and epithelium. A bacteriological examination revealed tubercular bacilli. The bladder was sounded on three different occasions with and without distension and no stone or growth was detected to account for the symptoms. It is well known in bladder surgery, cases are reported where a sound could not detect a stone from its location where an exploratory incision revealed it. As Englisch, Fenwick, Shede, Sir Henry Thompson and others advocate suprapubic drainage in painful tubercular cystitis and my colleague, Professor Mifflin, by whom the case was referred to the surgical ward, approved of an exploratory incision, a suprapubic cut was made July 13th. No stone nor

growth was found. There was a suspected ulcerated surface of the bladder wall. The bladder and wound was closed at their superior extremity and a drainage-tube inserted. On account of darkness and the absence of an electric light, the scraping of the ulcer was deferred. To July 16th, the temperature was not above 99.6° nor had there been any marked pain. On July 16th there was some return of the "old pain," and temperature 100.2°. The patient was anæsthetized on same day and the ulcer near the left ureteral opening cautiously scraped by Volkmann's spoon, and with the aid of the portable electric light. The bladder was irrigated with peroxide of hydrogen. The removal of patient to the operating room gave no ill effect as was feared. On July 17th, temperature 99° and pulse 76. On July 18th pain was excruciating along the left ureter, extending somewhat over the abdominal muscles and back. Counter-irritation by mustard was applied, followed by poultices. Dry mustard was rubbed into a piece of thin flannel which covered an area as large as the required poultice. Another piece of flannel was laid over the face of the linseed. There is thus obtained a poultice between two layers of flannel. The side containing the mustard was placed next to the skin till smart counter-irritation was produced, then the poultice was reversed. If continued heat is desired, as in this case, the ordinary poultices are renewed every two hours. Enema was ordered and *berberis* 2x, was prescribed. In two days the patient was relieved of pain except at the daily irrigation of the bladder. The muco-pus from the bladder gradually disappeared with noticeable improvement of the bladder-wall. Examinations of the urine were frequently made without acquiring further information. On August 1st, there was another intense paroxysm of pain for which the same treatment as before was prescribed. This proved ineffectual and the patient was delirious with the pain. Morphia hypodermically, was administered. The principal remedies were *belladonna* with *berberis*, *terebinthina*, *chimaphila*, etc., at different times, but no benefit was derived except the delirium was quieted. On August 4th Professor Mifflin suggested *uva ursi* 6 gtt x, in water, in alternation with *belladonna* 2x, half hourly, with continuation of other treatment. The change for the better was immediate and a reddish deposit on the dressings was reported. The temperature from 103° to 104° fell gradually to 100° and the pulse from 135 to 145 became 85. The patient thereafter made an uneventful recovery. The bladder was allowed to close the latter part of August. It was completely closed in four weeks and the external wound in two weeks.

The late Dr. J. Marion Sims, made successful incision into

the bladder to secure rest of the organ and facility for local treatment. This suggested the same operation to Dr. Emmet, to whom belongs the credit of having popularized a most benificial procedure in judiciously selected cases. It might be added, it is believed all the well known precautions were successfully used to prevent the so-called "back-telling." Our capacity for differential diagnosis between stone in the kidney or ureter and a tubercular kidney, depends, says Dr. Fenwick, "upon our skill in cross-examining," and such diagnosis is "an impossibility." The best indications depend upon the family history of the patient, which in this case was tubercular. Did *uva ursi* act on renal calculus or tuberculosis? What was the reddish deposit on the dressings reported by a competent and conscientious nurse? A careful bacteriological examination preceding the last attack was made and no tubercle bacilli found. It may be remembered tubercle bacilli are found with difficulty and often unsuccessfully in acid urine.

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A CASE OF GASTRO-INTESTINAL SYPHILIS.—Dr. K. Buday reports the case of a workman  $\text{wt. } 47$ , who was afflicted with a papulo-pustular eruption upon the face of the size of a pin's head for two years, and who suddenly, while in fair health, began to suffer from prostration and colicky pains in the epigastrium. Eight days after he passed blood in his stools. His appetite was good, and there were neither nausea nor vomiting. On examination, there was discovered, in the umbilical region, a tumor of the size of a hen's egg, hard in consistence and difficult of making out as to outline, not displaceable and unaffected by respiratory movements. The skin over the neoplasm was displaceable and of a normal appearance. Temperature,  $101^{\circ}$ . The tonsils and vault of the palate were red and swollen. Laparotomy was done, and a nodulated tumor of the size of two fists was found, extending to the spinal column. To the right of the median line were a number of constricting adhesions, which necessitated the resection of five inches of intestine. The patient succumbed to the operation. The growth was formed by a mass of gummatus mesenteric glands. The stomach and small intestines presented numerous ulcerations, evidently of gummatus origin; the base of the tongue, liver and kidneys also showed gummata either undergoing ulceration or still undisintegrated. Microscopic examination revealed all the lesions characteristic of tertiary syphilis.—*La Semaine Médicale*, No. 53, 1895. (Drs. G. Hayem and P. Tessier have reported (*Revue de Médecine*, No. 4, 1899) a case of intestinal syphilis in a patient  $\text{wt. } 32$ , who was under treatment for a papulo-squamous syphilide, but who presented symptoms similar to typhoid fever. The necropsy revealed numerous ulcers in the ileum and large intestine. Syphilis localizes itself in the lymphoid organs, Peyer's patches and the solitary follicles. In the early stage only a small-celled infiltration is found; later, ulcers, with thickened edges, filled with purulent yellow-colored masses. A severe, long-continued diarrhoea, with bloody stools, is the most characteristic symptom. The writers believe that such cases are more common than would at first appear. Zeissl (*Lehrbuch der Constitutionellen Syphilis*, p. 288), though he has himself not observed such a state, mentions from the literature cases where the organs of digestion have been observed to have been affected with gummatus ulcerations or fibroid degeneration.—EDS.]

## EDITORIAL.

### STATE MEDICAL EXAMINATIONS.

WE are well aware that the subject of State Boards of Medical Examiners has been served up to the readers of medical journals in so many different forms that they would fain cry, "Enough!" —and yet the recent disturbance in the Pennsylvania board offers a temptation to say a final word on the subject not to be resisted. It fortunately did not originate nor affect the homœopathic section of the board, and into the specific causes of discontent, viz., the political log-rolling charged, and the unpractical character of some of the questions propounded, we do not care to enter. We would wish only again, in the light of experience already gained, to point to the absurdity—*sit venia verbo*—of the whole movement.

The ostensible purposes of the establishment of these boards were to elevate the standard of medical education and to protect the public from incompetent practitioners. Now, at first sight, these two purposes seem so nearly allied that it would appear an easy matter by one and the same means to accomplish them both. A little thought will prove that this is far from being the case. We all know that practical therapeutic skill is by no means coextensive with theoretical knowledge. The vast advances made in the completeness and thoroughness of medical science within the last decade has not been marked by a corresponding advance in the successful treatment of disease. The purely superficial development of the doctrine of asepsis and antisepsis does not come into consideration here at all, since internal medication based upon it has, in most instances, eventually proved a delusion and a snare. To raise the standard of medical education by means of an examination would require this latter to be thorough and largely theoretical, since the practical applications of the principles of medicine, although the most important, must always form the least extensive of the branches taught. Therapeusis is the apex of a pyramid the base of which is the whole broad field of medical science. An examination to test the firmness and strength of

this foundation surely cannot be condensed within the scope of five questions in each branch.

To test the fitness of a graduate to practice medicine and thus to protect the poor defenceless public from incompetent practitioners, an examination conducted on quite different lines is required. Here, too, five questions in each branch are manifestly inadequate. When, then, it is sought to accomplish the double purpose, the alleged *raison d'être* of the boards, by submitting five questions on each subject of the curriculum, the absurd futility of the attempt becomes painfully manifest. Neither the architecture nor the excellence of the "modern conveniences" of a mansion can be determined by examining specimen bricks.

A comparison between the examinations which here in the States blessed (?) with examining boards alone entitle to practice medicine with those conducted in England and on the Continent, must strike any one acquainted with the length and thoroughness of these latter as a splendid example of American humor. The grotesqueness of the comparison becomes perfectly resplendent when the personnel of the various boards is scrutinized, and when the true inwardness of many of the appointments and removals is known.

We feel confident that ere long we will witness a reaction against this boasted panacea, just as we see constant reactions against the material panaceas so persistently presented and so ruthlessly rejected. This, too, is a sort of coal-tar product, which will have to be materially altered before it will be found efficacious in the evils for the correction of which it has been introduced. In spite of laudatory notices and "unsolicited testimonials," the after-effects of this mode of treatment will soon become manifest, and sound reason and sober judgment will again assert themselves.

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PROFESSOR DUDLEY, DEAN OF HAHNEMANN MEDICAL COLLEGE,  
PHILADELPHIA.

PEMBERTON DUDLEY, M.D., has been chosen Dean of the Hahnemann Medical College, of Philadelphia, to succeed the late Prof. A. R. Thomas, M.D., and Charles Mohr, M.D., has

been made Registrar of the same institution, to fill the place made vacant by the resignation of Prof. John E. James, M.D.

Dr. Dudley is a worthy successor of the late Dean Thomas, and comes to his office well equipped to fill his responsible position. He is in the prime of life, and in perfect health. As a leader he is safely conservative, yet efficient and ably aggressive, and his administration will be brilliantly successful, redounding to his credit, and to the glory of old Hahnemann. He is an alumnus of the college, and he will receive the hearty co-operation and support of the trustees, faculty and alumni of the old institution. At the present time Dr. Dudley is President of the American Institute of Homœopathy, President of the Board of Health of the State of Pennsylvania, member of the Board of Medical Council of the same State, Professor of Hygiene and Institutes of Medicine in the Hahnemann College, etc. Physician, professor, author and State official, he bears the varied responsibilities of his many honors with a charming simplicity that springs from a strong, sincere character, increasing the admiration of his friends, and the respect of his opponents. Our readers will find a detailed account of his busy, successful life on page 101 of the "News," of the August, 1895, *HAHNEMANNIAN*.

Dr. Mohr has an enormous capacity for systematic detail work, which admirably fits him for the position of Registrar. For a sketch of his life, see "News" pages of this month.

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A CASE OF SPINAL APOPLEXY.—Dr. Goebel was called to a man of sixty-one years, with a good family history and no signs of syphilitic individual antecedents, but who drank a pint of brandy daily. He had been ailing for the past four years. One day in the winter of 1890 he was chopping ice in his yard when he was overpowered by a sense of giddiness, and he dragged himself to his room and laid down. In a short time he attempted to rise, but found it impossible. For fourteen days he lay in this state. His four extremities were anaesthetic; his arms and legs hung as of lead from his body, and no movement was possible. At the same time he experienced a painful constrictive feeling in his abdomen "as from a strap." Obstinate constipation and paroxysmal pains in the abdomen, often associated with vomiting. Urination was also slow and difficult. In three months these symptoms had gradually disappeared, so that he could get out of bed, but was bound to hold on to things. Sensation and motion had so far returned that he could hold a spoon. His "girdle-pains," vesical and intestinal disturbances, still remained. When seen he presented great general emaciation of the lower extremities, painfulness to pressure of the abdomen, patellar reflexes absent, cremaster and foot sole reflex slow to appear. A moderate degree of arterio-sclerosis was to be noticed. No signs of tabes; internal organs healthy as well as the cranial nerves. The writer explains it to be a case of spinal apoplexy occurring into the meninges and with a vast hemorrhage.—*Muenchener Medicinische Wochenschrift*, No. 41, 1895.

## GLEANINGS.

### GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D., AND FRANK H. PRITCHARD, M.D.

**A CASE OF BARLOW'S DISEASE (INFANTILE SCURVY).**—Dr. A. Freudenberg has recently observed a case of Barlow's disease after whooping-cough, which former resisted the classic treatment of rickets but was rapidly ameliorated and cured by antiscorbutic measures. A child (female) of two years, from the first few weeks of the spasmodic stage of whooping-cough presented a swelling of the gums, with a bloody oozing and a paretic weakness of both legs, with painfulness to pressure and a decrease of the patellar reflex. Urine normal. The little patient became extremely pale and perspired profusely. In spite of cod-liver oil and phosphorus, the disease progressed and the right lower extremity swelled considerably. The gums were then brushed with lemon juice and rapidly increasing doses of brewers' yeast, up to six teaspoonsful a day, were employed. A favorable result was noticed in a few days and a cure followed in a few weeks. From these results he is inclined to regard the disease as a form of infantile scurvy—*Archiv. Fuer Kinderheilkunde*, xix., 3-4, 1895. [I have seen rapid amelioration and a recovery follow in a similar case from merc. corr. 3x, one grain three times a day. In the April number of the HAHNEMANNIAN MONTHLY, 1895, a number of references are made to the literature of this affection, in an abstracted article. Dr. M. Deschere, in this journal, October, 1891, discusses the disease and its homœopathic treatment.—Eds.].

**LEUCÆMIA AND LONG CONTINUED PRIAPIISM.**—Dr. A. Kast referring to the fact that persistent priapism has been remarked by a number of writers as occurring as a complication of leucæmia, particularly in its advanced stages, records a case where it was long the only symptom of the disease. A man of 42 years awakened one morning with a very painful erection, which persisted the entire day in spite of all treatment. When the writer saw him the rigidity of the penis had persisted for eighteen days. His organ was in complete erection; it was hard, violet-colored, painful to touch but in no part was it asymmetrically enlarged. The examination of the nervous system, blood and viscera was negative. After having lasted for about two months it disappeared little by little but he became impotent. Then the pathognomonic signs of leucæmia, characteristic state of the blood, enlargement of the spleen and liver appeared; the glands were not affected. On both sides of the penis there was induration occupying the whole organ. The patient succumbing to his disease the penis was examined post-mortem. The corpora cavernosa were found to be transformed into hard masses of connective tissue but at their periphery there was a cellular infiltration similar to the spongy portion of the urethra. Therefore, there had been leucæmic thrombosis (white thrombosis) of the tissues of the penis which had produced mechanically, a stagnation of blood and consecutively a sclerosis or diffuse hyperplasia of the connective tissue.—*Zeitschrift Fuer Klinische Medizin*, xxviii., 1-2, 1895. [Prof. Osler (*The Principles and Practice of Medicine*, 1892, p. 702), also mentions this curious symptom which may be present in a large number of cases. He cites Dr. Edes, who reports a case like this one, where it was the first symptom of the disease, and Dr. Peabody, where the priapism persisted for six weeks. He states that the cause is not known. The majority explain it by a local affection of the penis and notably a thrombosis.—Eds.].

**VARIOUS NERVOUS SYMPTOMS, AND ESPECIALLY FACIAL PARALYSIS, WHICH MAY ACCOMPANY HERPES ZOSTER.**—Prof. W. Ebstein describes a number of nervous symptoms which may accompany herpes zoster, and above all, those eruptions of the disease upon the face, head, back of the neck, and throat,

where paralysis of the muscles innervated by the affected nerves may follow. These disturbances are far rarer than the sensory sequelæ, of which neuralgia is the most important. Sometimes there is seemingly no actual paralysis (motor), but disturbed motion from the associated painfulness. Different writers have noticed that when the eruption appears upon the upper extremities that it may be followed by actual atrophic paralysis of more or less muscles supplied by the brachial plexus. It would persist for about six months and then disappear. In the lower extremities these sequelæ seem to be still rarer. Hardy has observed a herpes zoster of the sciatic nerve followed by complete amyotrophic paralysis of the muscles of the leg, which was permanent. Herpes zoster of the course of the cranial nerves has been followed by paralysis of the facial or eye nerves, or even of both. Facial paralysis is prone to follow that variety of the herpes localizing itself in the cervical plexus and especially of the third cervical nerve. It is usually accompanied by hyperesthesia, neuralgias, anæsthesia of the branches of the trigeminus with sensory disturbance in the cervical plexus. The paralysis may be slight and transient, or severe and persistent. In some cases the whole condition may be due to a gouty neuritis.—*Hospitales Tidende*, No. 28, 1895.—[He does not mention the most frequent cause of (toxic) herpes zoster, arsenic. Dr. Seutin, of Belgium, claims that cantharis is the true homeopathic specific for this disease; it is rare that any other remedy will be needed.—EDS.]

**HYSTERICAL INSOMNIA.**—Hysterical subjects are quite frequently sufferers from insomnia, or their sleep may be unrefreshing, interrupted and disturbed by dreams. Owing to the readiness with which these patients acquire a habit, many of the hypnotics in common use are positively contra-indicated. This applies with especial force to opium and its preparations. In this way not a few hysterical subjects have become morphine habitues. Chloral is also an objectionable hypnotic in the majority of these cases, while the bromides are often inefficient. Some years ago it would have been difficult to suggest an ideal soporific for these cases—one which would produce normal, refreshing sleep, rapidly, safely, and pleasantly. Now, it is claimed, that difficulty has been practically solved by the introduction of trional. The numerous reports that have thus far appeared on this remedy coincide in assigning to it the position of an extremely efficient hypnotic. A prompt and reliable effect can always be anticipated in cases of hysterical insomnia from doses of 1.0 to 1.5 grammes, provided the sleeplessness be not due to pains. Any possible after-effects can be prevented with certainty during its continued use for some time, if trional be always administered in a large quantity of warm fluid, and in the day following its administration increased diuresis be secured by one or two bottles of some carbonated mineral water seltzer, apollinaris), as well as regular movements of the bowels. If the precautions be considered trional can be regarded as a perfectly safe hypnotic. This is distinctly shown by the fact that in many psychiatric clinics the remedy has been employed for more than three years without any noteworthy after-effect. In the sleeplessness of hysterical persons, which is usually due to cerebral excitement, trional will prove an admirable sedative and soporific which may be given for long periods without danger of habituation or any deleterious influence upon the general health.

**ACUTE NEPHRITIS ASSOCIATED WITH ECZEMA.**—Dr. C. Bruhns, of Leipsic, calls attention to the fact that certain forms of eczema, not of toxic origin, may be associated with acute nephritis, respectively, albuminuria. It is by no means rare. The renal affection is to be attributed to the skin disease. The close connection between the skin and the kidneys is well known. A certain predisposition must be necessary for albuminuria to be brought about by eczema. A case of impetiginous eczema is reported by Salvioli. *Contributo all' Patologia dei Reni; Archivio per le Scienze Mediche*, vol. iii., fasc. iv., where, on the forty-third day of the disease, a nephritis set in, which was attributed to the skin disease which was spread over the whole body. Three weeks later, death followed, and the necropsy revealed a glomerulo nephritis. Other writers have described various forms of nephritis, complicating varieties of eczematous eruptions.—*Berliner Klinische Wochenschrift*, No. 28, 1895. [Le Gendre (*La Semaine Médicale*, No. 7, 1894) also advises examination of the urine in children who are apparently ailing, and who present eczematous eruptions, for the eczema may be of renal origin. I know of a young boy in whom albuminuria and an eczematous eruption alternates—when the one is out the other is in.—EDS.]

## GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D. AND H. L. NORTHRUP, M.D.

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**SUDDEN DEATH IN A CASE OF FRACTURE OF THE PATELLA**—Dangers of Massage.—M. Cerne reports a case of simple, transverse fracture of the patella, with little separation of the fragments, and but slight effusion into the knee-joint. The effusion soon disappeared. At the end of three weeks the patient, who was strong, active, and of a good constitution, wished to know when he could rise and leave the hospital. He could easily raise his limb from the bed. There was some motion, but limited, in the knee-joint. The leg, however, was clammy, both above and below the articulation.

The writer intended soon to supply a silicate dressing, but was desirous first of facilitating the absorption of the exudate, of promoting the nutrition of the quadriceps (which, according to most authors, atrophies), and of rendering the joint somewhat mobile. He accordingly prescribed gentle massage to the thigh, as was his usual custom. There was at this time no appreciable pain in any part of the limb. Massage had been practiced on several occasions, particularly on one day, when, on the next day the patient was suddenly seized with suffocation and died within a few minutes. At the autopsy the pulmonary artery was found obliterated by large thrombi derived from the deep femoral vein. It is not absolutely demonstrated that massage should be blamed for the result. Nearly twenty-four hours had elapsed since massage had last been performed, but it is undoubted that the practice was dangerous and that it might have determined this migration of a clot. It is very possible that, by breaking up the clot, it had facilitated its transmission.—*La Medicine Moderne*.

**LIGATION OF VASA DEFERENTIA FOR PROSTATIC HYPERSTROPHY**.—Brown (New York), describes a case, 72 years old, with a greatly enlarged prostate, retention of urine, etc. After catheterization and rest in bed absolute retention persisted. Under cocaine, Brown made an incision over the left cord, the vas deferens was drawn out and ligated in two places about one-fourth of an inch apart. The same process was done on the other side. Seven or eight days after this he began to pass a very little urine voluntarily. He gradually improved, until at the time of his discharge, he was able to pass all the urine, with the exception of three ounces of residual urine. Later on it was found that this amount had diminished still further, and he now considers himself well.

Palpation per rectum shows a very decided diminution in the size of the prostate. The operation on this old man was proposed because the operator had seen a fatal result follow castration in a man of this age, and one who was apparently in a more vigorous condition. In view of Dr. White's remarkable results on dogs, it was thought there would be no harm in trying this trifling operation in the present case. The amount of improvement was surprising and can doubtless be attributed to the operation. After the operation the man complained of a burning sensation in the legs and soles of the feet, which was entirely different from anything he had ever experienced before. He no longer complains of this sensation. There is no atrophy or tenderness of either testis.—*American Medico-Surgical Bulletin*.

**CANCER OF THE TONGUE**.—Buchanan says that he has resolved never to operate upon cancer of the tongue unless the disease is limited to one side of the anterior half of the tongue and has not yet invaded the loose mucous tissue in the floor of the mouth.—*Edinb. Med. Jour.*

**A CASE OF CONGENITAL ABSENCE OF THE VERMIFORM APPENDIX**.—Swan, in a paper read before the Philadelphia Pathological Society, presented a specimen taken from a male subject in the dissecting-room. The apparent age of the individual was forty years.

In examining the external aspect of the cæcum, as it lay in the body, no trace of a vermiciform appendix could be found. The intestines were then removed and a careful search instituted, but still no tissue was discovered which in any way resembled the appendix. The longitudinal bands of muscular fibres were traced

down to their termination, and the wall of the bowel presented a perfectly smooth appearance, the serous covering of the bowel presenting no cicatricial tissue, thus indicating that this portion of the intestinal canal had not suffered at the hands of the surgeon. On examining the cecum from its internal surface, the ileo-cecal valve was seen to be normal in situation and appearance. The normal situation of the vermiform appendix is on the posterior wall of this portion of the intestine, just internal to the position of the ileo-cecal valve, and on the mucous membrane of the bowel is seen a dimple marking the opening into the lumen of the appendix. No such dimple could be detected in this specimen. Situated below the orifice of the ileum is an oval ulcer, which has involved the coats of the bowel down as far as the serosa. The base of this ulcer is smooth and shining, the margins are elevated, and for some distance from the raised border there is presented an appearance resembling that of several miliary tubercles. A second ulcer, similar in appearance, is seen at the apex of the cecum. Owing to advanced post-mortem changes, microscopic sections, which were made, failed to show the characteristic appearance of a tuberculous ulcer, and the diagnosis of tuberculous ulcer has to be made from the macroscopic appearance alone. The abdominal wall presented no scar which would point to the performance of a coeliotomy at any time.

Taking these facts into consideration, Swan calls this a case of congenital absence of the vermiform appendix. The explanation of the condition is that the head of the colon has developed equally in all directions, thus including in the cecum that portion of the intestine which is usually undeveloped and which represents the lumen of the large intestine as it is first formed.—*University Medical Magazine.*

## GYNAECOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D.

**A METHOD OF COMPLETE VAGINAL HYSTERECTOMY**—Richelot.—He condemns the use of ligatures and sutures, and uses only the large clamps devised by himself. After careful disinfection of the patient, the operator seats himself between the patient's legs and opens the abdomen, draws the uterus forward on the abdomen, enucleates the myomatous nodules, or removes them by morcellement. The anterior peritoneal fold is now separated, and the bladder and ureters pushed down with it. The first and second fingers of the left hand are now pushed up deep into the vagina in front of the cervix. The vesico-uterine fold is now cut through with the scissors and the forefinger introduced into the opening. Under its guidance the attachment of the vagina is divided to the base of the broad ligaments. There is very little bleeding. The entire hand is now introduced into the vagina, the thumb anterior, the fingers posterior, grasping the broad ligament. The posterior fold of the ligament is divided with the blunt blade of the scissors, and now the right hand thrusts through this opening the posterior blade of a large Richelot's clamp, and the anterior blade is placed on the front of the ligament. When the operator closes the clamp, the assistant lowers the uterus a little. The other side is treated in the same way; the ligaments are divided, and finally the posterior insertion of the peritonium is separated with two or three snips of the scissors. An iodoform gauze tampon is placed in the vagina, the abdomen closed, and the operation is completed sooner than would be expected.—*Centralblatt für Gynäkologie*, No. 37, 1895.

**ECTOPIC GESTATION**—Dr. W. V. Hanscom, of Rockland, Maine, reports two cases on which he operated. In the first case the rupture was so close to the uterus that there was not enough left of the tube to tie off; so it was cut close to the uterine cornua and a continuous layer of fine catgut was introduced, closing the end of the tube completely, and also closing the peritoneal surface of the broad ligament in the same way. A drainage-tube was used, and the patient recovered. The second case was an interstitial pregnancy. In opening the abdominal cavity about two inches from the umbilicus, the bladder was accidentally incised, but was sutured at once with a running catgut suture, and gave no further trouble.

When the peritoneum was opened, a black mass encapsuled in a very thin membrane presented high up under the umbilicus. The sac was ruptured, and a large amount of disorganized, coagulated blood poured out with the fetal remains. The uterus was ruptured on the right cornua through to its cavity. The Fallopian tube was torn completely off leaving a hole in the uterus through which all the fingers of the hand could be passed. The ragged hole in the uterus was cleaned out, the edges trimmed, about one-third of the uterus cut away, and the rent closed with two layers of catgut. Persistent vomiting commenced on the third day becoming green and fecal in odor, but without signs of pus or peritonitis. Morphia relieved the vomiting, but the patient failed rapidly. A tube was introduced, about four feet being introduced, and a gallon of water injected without effect. The enemas were made saline with mag. sulph., and finally turpentine was added. After about twenty-four hours of this work, and the injection of some twelve gallons of fluid, the vomiting was checked and the peristaltic action of the paralyzed bowel was started up. Acute albuminuria, with a high temperature, developed in the third week, but yielded to a skim-milk diet and to arsenicum 3x.—*Private Reprint by the Author.*

**ENDOMETRITIS; FROM THE TRANSACTIONS OF THE GERMAN GYNAECOLOGICAL SOCIETY, JUNE, 1895.**—Menge examined seventy-four uteri which had been cut out of the body, and arrived at the following conclusions from a bacterial point of view :

1. Bacteria do not live in the normal uterine cavity, in the secretion, or in the tissues of the mucous membrane, which will thrive in the culture materials ordinarily used.
2. Bacteria do not live either in the secretion or in the mucous membrane of such uteri as show the characteristic anatomical signs of the so-called chronic endometritis of the body or of the cervix. Uterine cavities containing dead material are excepted from this statement.
3. If the cervical canal is healthy and functionates physiologically the development of bacteria in dead material in the uterine cavity only takes place when bacteria are introduced directly into the uterine cavity by artificial means. In spite of the negative evidence of bacteria in chronic endometritis, Menge does not deny that besides the gonococcus and bacillus tuberculosis there may be other bacteria which may play an etiological rôle in the development of endometritis.—*Centralblatt für Gynäcologie*, No. 27, 1895.

## OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

CONDUCTED BY  
CHAS. M. THOMAS, M.D.

**THE RELATION BETWEEN NOCTURNAL ENURESIS AND ADENOID VEGETATIONS OF THE NASO-PHARYNX.**—Dr. Groenbech, of Copenhagen, reported thirty cases of adenoid vegetations of the naso-pharynx, accompanied by nocturnal enuresis. (Of 192 cases of vegetations examined in 1892, 2 i, or 13 per cent., were attended by nocturnal incontinence of urine.) Of 23 patients operated upon, 12 were cured immediately, or shortly after the operation, of the bladder difficulty, which had been in existence for several years, and no relapse occurred during the time of observation. Five cases were notably ameliorated; 2 were slightly improved; and 1 was under observation for only 9 days, during which no enuresis appeared. In 3 cases only did the incontinence remain uninfluenced by the operation. The author narrates a case showing a relation between enuresis and obstruction of the nasal respiration. When the latter is re-established the former ceases; it augments and diminishes coincidently with the embarrassment of respiration through the nose. The author's conclusion is, that in each case of bed-wetting the nose should be examined for vegetations, the most frequent cause of nasal obstruction in children.—*Revue de Laryngologie*.

**INSUFFLATION OF SODIUM CHLORIDE INTO THE NASAL CAVITY FOR RELIEF OF PAIN.**—Dr. Capp recommends the insufflation, through an ordinary insufflator, or other appropriate tube, of from two to four grains of pulverized table salt as a measure tending to give immediate relief in facial pain or headaches arising from

trifacial irritation from decayed teeth, eye-strain, or from other causes, such as ear affections, hysteria, or uterine reflexes. The measure was first applied, according to the author, by Leslie, who had successfully employed it in the treatment of obstinate and long-standing cases, as well as acute neuralgia, headache, faceache, earache, toothache, and bronchial asthma. The application causes about the same temporary discomfort as would a pinch of snuff, but is not followed by bad results, and is usually successful.—*Texas Medical Journal.*

**CHENOPODIUM IN OTITIS INTERNA.**—Linnell states (*Journal of Ophthalmology, Otology, and Laryngology*) that our means of curing or even ameliorating affections of the internal ear are so meagre that anything which promises to extend them is deserving of record. He then narrates a case in which it is difficult to make a positive diagnosis, but a sudden exudation, serous or bloody, in the labyrinth, followed by inflammation, and preceded and followed by a slight catarrhal otitis media, seemed to afford the most rational explanation of the symptoms exhibited.

The improvement in the case narrated seemed to him to be fairly attributed to the remedy prescribed (chenopodium 6x). The condition had lasted for upward of three years, and had not been benefited by previous treatment. No other treatment was employed while taking chenopodium.

He further reports a second case, where there was an implication of the left labyrinth in connection with slight otitis media catarrhalis chronica of both ears. The symptoms were: Deafness in left ear for several years; no tinnitus; consciousness of the ear; sensitive to musical sounds; deaf for the watch and voice. Rmt., normal; Lmt., somewhat retracted and dull; no light spot; good vibration with otoscope. Eustachian tubes dilatable. Bone conduction diminished from left mastoid. In this case, the prescription was chenopodium 6x, and permanent improvement in all the symptoms followed.

In the proving of chenopodium we find recorded "progressive deafness to the voice, but great sensitiveness to the sounds of passing vehicles, each one of which sounded like roaring of immense cannon right into his ear, the same sensitiveness to other sounds, for example the tea bell; also buzzing in the ears."

This condition, deafness to the voice but sensitiveness for other sounds, was present in both of the cases recorded above, and Linnell has found it a reliable indication for the remedy. In addition, he puts on record as cured symptoms, the following, viz.: absent or deficient bone conduction restored under the use of the drug; roaring tinnitus synchronous with the action of the heart. A consciousness of the ear; sensitiveness to musical sounds and to cold. Hearing better for shrill, high-pitched sounds than for low tones.

**A CASE OF INTERSTITIAL KERATITIS WITH SYNOVITIS, BOTH BEING UNILATERAL.**—In support of the theory of the connection existing between interstitial keratitis, Thomson cites a case in a girl of sixteen, suffering from amenorrhœa and anaemia. While the case was under treatment the right eye became inflamed; with the characteristic symptoms of diffuse grayish infiltration and isolated opacities, under a normal epithelium, advancing from the periphery toward the centre of the membrane, with dense ciliary congestion. Anterior chamber free from deposit. Full dilatation of pupil under atropine. Within a week effusion into the right knee-joint developed. The swelling was not tense, was evenly distributed, and painless; passive motion was not impeded and the skin was of normal color. No fever; no evidence of syphilis in physical signs or family history. The synovitis lasted six months and disappeared of itself, treatment having no effect; the keratitis ran the usual course, the cornea becoming normal, except for a slight central haziness, in about a year. The patient was under observation for nine years, with no return.—*The Lancet.*

**A METHOD OF HOLDING CHILDREN FOR NOSE AND THROAT TREATMENT.**—Freeman says, the child should be taken on the lap of the assistant whose arms should pass beneath those of the patient and be clasped above his head. In this way the more the child struggles the more the assistant's hands are pressed down, and the more firmly the child is held. The patient's legs are held between the legs of the assistant, so that kicking is almost entirely prevented.

The author has used this method for several years and finds it most satisfactory even for delicate operations.—*Philadelphia Polyclinic.*

## MONTHLY RETROSPECT OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D.,  
FRANK H. PRITCHARD, M.D., AND F. MORTIMER LAWRENCE, M.D.

**ACIDUM PHOSPHORICUM IN GASTRIC AFFECTIONS WITH MELANCHOLY.**—Dr. K., a correspondent of a Dutch homœopathic journal, relates the case of a woman, *et. 36*, married, and the mother of eight children, who, for some time, had been suffering from a sort of melancholy, which so depressed her that she found it nearly impossible to fulfill her duties as mother and housewife. No cause could be discovered. Her circumstances were good; she had undergone no great emotion, though the sudden death of a member of her family had aggravated her condition. Apparently, her disease had begun with a weakness of the stomach. She had but little appetite, experiencing always pain and distension of the stomach after eating; the food seemed to lie for a long time in her stomach and would not undergo digestion. As it is known, depressing emotions may be the starting-point of gastric affections, and, vice versa, a stomach disease gives rise to a depression of psychic life. He therefore administered acid. phosphor. 6x, ten drops three times a day. Later he learned that she was soon restored to health by the remedy.—*Homeopathisch Maandblad*, No. ii., 1895.

**PARACENTESIS PERICARDII.**—Dr Kidd records a striking though transient result from paracentesis of the pericardium in a patient of thirty-four years, with contracted kidney, uræmic asthma and right-sided pleuritis. Puncture of the pleura had twice greatly relieved, but pericarditis set in, with dyspnœa and cardiac weakness. Paracentesis of the pericardiac sac was done twice, with a successful result, but at the third puncture no serum flowed. Death took place a week alter. He presents the following conclusions; 1. Paracentesis of the pericardium is a justifiable measure. 2. Under the usual precautions it is innocuous. 3. The point of puncture is the fifth intercostal space, 25 cms. from the sternum. 4. With existing left-sided pleuritic adhesions, the sixth intercostal space may be selected. 5. Instruments: trocar and canula. 6. Method: with or without aspiration—*Medizinische Neuigkeiten*.

**THE SYMPTOMATOLOGY OF KALMIA LATIFOLIA.**—According to Dr. J. R. P. Lambert, the most striking points in the pathogenesis of *kalmia* are the pains which affect all parts of the body, usually of a transient character, but sometimes very persistent and severe. They usually affect a large part of a limb at once, or several joints, and shift their situation rapidly. This last peculiarity is most characteristic. In addition to the pains, vertigo and dizziness, with or without nausea and impaired vision, occur in nearly all the provings. It has also a prominent action on the heart.

*Kalmia* acts very prominently on the nervous system, not only on the sensornium and brain, but also on the spinal cord and nerves. In nearly all the provings we find vertigo and dizziness complained of. This symptom is aggravated on stooping and on looking downward, and sometimes also towards noon and on arising from seat. It may be accompanied by nausea and even vomiting, and by impairment of vision, which may amount to almost complete blindness. There is also confusion of the brain, causing inability to collect one's thoughts and for study. We find, also, that it produces various pains in the head. These have a preference for the right side and affect chiefly the frontal and temporal regions. Occasionally the pain is confined to the occiput or vertex, or

is strictly one-sided (usually right), affecting the occipital and temporal region. Frequently the pain extends from the head down the nape towards the upper dorsal region or down the sides of the neck, or when it is situated towards the front of the head, down into the teeth. On the other hand, the pain may originate in the back, pass up over the vertex to the frontal region, but not into the eyes. Another important symptom is that the prover often awakes with a headache. The above symptoms promise great things from *kalmia* in various forms of headache, even migraine, and in supra-orbital and facial neuralgia, and clinical experience confirms its value in these affections.—*Journal of the British Hom. Society*, July, 1895.

**THREE IMPORTANT INDICATIONS FOR SEPIA.**—Dr. Lorbacher, of Leipsic, sets forth three important indications for sepia which are not generally known of this polychrest, namely, the prodromal symptoms of apoplexy, whooping-cough that drags on and refuses to be cured, and hypostatic pleuritis.

Under the first, the disposition and prodromal stage of apoplexy, he not only understands the so-called apoplectic habitus, but also the acquired variety as is observed in drinkers and in those whose occupations are sedentary. The usual symptoms are stiffness of the back of the neck, described by some patients as a feeling "as though they had a stick in their neck," staggering vertigo, especially on exercising in the open air, anxiousness and a feeling of fear, a fear of severe sickness, intermittent heartbeat and a certain degree of torpor and sleepiness. All these symptoms are presented by the provings.

A farmer of some fifty years, of a stocky build, inclined to hypochondria, and troubled from time to time by hemorrhoids, who without being a habitual drinker, took from time to time "a little nip." Gradually a certain degree of abdominal prominence had developed, while the threatening signs of an apoplectic tendency became prominent [arterio-sclerosis—Eds.] as stiffness of his neck, vertigo, occasional throbbing headache, slight and transient loss of consciousness, anxiety, fear of apoplexy, while his hemorrhoids were not so pronounced nor so frequently troublesome. Venesection had several times been done, with only a temporary relief. Abstinence from alcohol had no decided influence. Sepia 12x was prescribed, four drops twice a day, later every other day, and still later less frequently. In two months a decrease of the symptoms was remarked, and gradually they were reduced to a minimum. He lived eight years longer, and had no apoplexy, though he did not entirely renounce his "nip."

This result encouraged the writer to employ it in similar cases, and though the results have not been so striking, yet he thinks it a valuable prophylactic.

The cases of whooping-cough where sepia is indicated are usually of eight weeks or longer duration; the paroxysms have, in general, decreased in number and violence, though they do not seem to want to disappear, especially before midnight. The patients are reduced in strength and dyspnoic, irritable, tearful, easily angered or indifferent and apathetic. The characteristic bronchial stasis of the disease in such cases would seem to explain the indication of the remedy here. In a number of cases he has found sepia 12x to do good service in this state.

This variety of pleuritis is not the acute but rather a hypostatic form, which sets in insidiously, with other diseases. Kunkel, of Kiel, and Hansen, of Copenhagen, have called attention to it here. The writer has used it successfully in the pleuritic complications of pulmonary tuberculosis, where the pains are stitching and violent as with kali carb., which is analogous in action to sepia here, but where bryonia and kali iodatum which usually do such good service in ordinary pleuritis fail. Still, at least, one or more characteristic sepia symptoms as aggravation from walking in the open air, which Kunkel regards as eminently decisive for the remedy, should be present.—*Archiv Fuer. Homoeopathie*, No. 11, 1895.

**BERBERIS VULGARIS IN RENAL COLIC.**—Dr. P. Pinart, of Barcelona, was suddenly called to a man of forty-five years of herculean constitution, addicted to alcohol, and a stevedore on the docks who complained of an atrocious pain in the region of the right kidney, with repeated rigors, nausea, vomiting with cold sweating. His urine was suppressed. Renal colic was diagnosed, and berberis vulg. 3x was administered every hour. After the third dose the pain diminished and he passed urine which contained a great quantity of sediment and gravel. The patient made an uneventful recovery.—*Revista Homoeopatica*, No. 9, 1895.

**AMMONIUM BROMATUM IN BRONCHIAL ASTHMA.**—Dr. Greenfield records the

case of a patient who had suffered for several years from bronchial asthma, the last seizure having lasted for six weeks, giving him no rest either day nor night. He could only pass his nights in the sitting position ; at the same time, he experienced great anxiety and a rattling râle was audible. *Stibium arsenicum 4x*, yielded only a transient result. A continual tickling in the larynx augmented the cough and increased his dyspnoea. This symptom led to the prescription of ammonium brom. 2x, which aborted the attack in twenty-four hours.—*Maand-skrift Før Homœopathi*, No. 2, 1895.

**KALI BICHROMICUM IN HEART DISEASE.**—Drs. Ide, of Stettin, Germany, regards kali bichr. as worthy of confidence in the management of heart affections though it has been little used in this sphere. He has found it to do good service in angina pectoris of gastric origin, but he would think it more indicated in essential heart weakness, especially in chronic myocarditis. He had under treatment a case with decided cardiac incompetency, great general weakness and œdema around the malleoli. The patient (a female), from sheer weakness, was unable to speak aloud, and, at times, was wholly voiceless. Kali bichr. here did efficient service. Here it is analogous in action with arn., cuprum, glonoin, and veratrum as well as arsen., brom. and digitalis.

All the potash salts have an affinity for the heart where especially the dyspnoea, sensation of pressure and painfulness in the chest, with the violent and anxious palpitation point to its homœopathicity in this sphere. In death from poisoning by this drug the heart first fails.—*Zeitschrift Des Berliner Vereines Homœopathischer Ärzte*, Bd., xiv., Hft., v., 1895.

**RUMEX CRISPUS IN COUGH.**—Dr. J. P. R. Lambert directs attention to the value of rumex in laryngeal cough. The cough itself is irritating, dry and spasmodic, appearing in paroxysms. It is provoked by a sensation of tickling in the sternal notch, or it may be lower, in the middle or lower portion of the tube. It may be brought on by lying down or from turning from the back to the side or by passing from the air of the room into the open air. Its principal characteristic is a tickling beneath the sternum. The remedy also acts upon the skin, determining an intense pruritus which is especially noticed on undressing, at night. This may be accompanied by an eruption of small papules.

Many remedies have a similar action in cough and especially hyoscyamus, phosphorus, causticum, conium, lachesis and finally, veratrum album.

*Hyoscyamus* acts especially upon the larynx, causing hoarseness, a dry cough, which is also spasmodic and induced by an irritation of the larynx and pharynx. It is aggravated by lying down and alleviated by sitting up. (Ferrum and managanum have the opposite characteristics.). *Hyoscyamus* is also frequently indicated where no position gives relief.

*Conium* has a similar action, with the peculiarity that the cough is more severe in general, and is worse when the patient retires.

*Causticum* also has an influence upon the larynx which may extend down into the bronchi. The hoarseness may aggravate into complete aphonia which is always very marked. The patient complains under causticum, of not being able to cough with sufficient force and it seems as if a deep inspiration would clear his bronchial tubes of the abundant mucus which obstructs them.

*Lachesis* is also analogous in action upon the larynx ; there is characteristically a great sensitiveness on pressure to the outside of this organ.

*Phosphorus* produces a tickling in the larynx and aphonia, yet its action is expended upon the pulmonary parenchyma and the bronchioles. As with rumex it causes tickling behind the sternum but it is lower down ; yet there is a sensation of constriction of the chest which is lacking in rumex. Phosphorus also has abundant expectoration and though the provings of rumex only present a scanty expectoration yet it might be of service in the characteristic cough with profuse sputa. At any rate it should not contra-indicate its use where the other symptoms correspond.

*Veratrum album* presents among other symptoms, deep, cavernous cough, accompanied by irritation of the smaller bronchi.

A characteristic symptom of rumex is sensation of a thread hanging down into the throat with a painful zone extending down upon the left side of the sternum. Causticum also has this peculiar symptom, yet especially located in the median line.—*Revista Homeopatica*, No. 9, 1895.

**KALI BICHROMICUM AND ITS ACTION UPON THE STOMACH.**—Dr. Ide, of Stettin,

Germany, states that kali bichrom. exerts an influence upon the stomach ranging from simple dyspepsia to the round (gastric) ulcer as in arsen. There is a yellow coating upon the root of the tongue, as with merc. iod., flavus, a mapped tongue as arsen., calc. carb., lach., lyc., natr. mur., nitr. acid., ran. sc., tarax., a dry, red, smooth and fissured tongue, with a bitter taste, sour eructations, pyrosis, as well as putrid eructations as with bism., cocc., hepar, phell., sang., sulph.; nausea and bitter vomiting, mixed with mucus, which may be drawn out into long threads, often after eating and drinking. A sensation of fulness in the stomach, even after eating even so little, slow digestion, burning, pressive pains in the stomach, several hours after each meal.

Therefore, we here have the symptoms varying from a simple dyspepsia to the severe forms of gastric catarrh. In chronic gastric ulcer it is one of our best remedies [so also says Fraser, of Edinburgh, an allopathic authority in *materia medica*—Eds.]. Some writers recommend it especially to calm the severe pains. The ulcers of the remedy are characteristically painful.

The gastric affections are aggravated by meat and especially by beer, and the drug is one of our best remedies in the dyspepsia from abuse of beer (as well as aloes and ledum pal.). There is often a craving for acid drinks. In the duodenum it produces and cures ulcers, as well as in the lowermost portions of the intestines, where it resembles especially the mercurials, and, above all, merc. corrosivus, together with cantharis.

The passages are often jelly-like, bloody or brownish and watery in appearance, or foamy, often painless and (odorless, as asth., asar., hyos., paulin., rhus), often associated with painful urging and tenesmus. The diarrhoea is worse, especially in the morning, also in the evening, after beer, in the early summer, appearing periodically every year and ameliorated by eating (arg. nitr., brom., chel., hepar, iod., lith. carb., lyc., natr. carb., petr., sang.).

The constipation which kali bichr. cures is usually connected with colic, and has a characteristic feeling of hair in the anus. Besides this anal sensation there is another characteristic sensation in this region, "a sensation as if a plug were in the anus," which is similar to that in the throat. The patient cannot sit still on account of this feeling, as with bry., crot., lach. The sensation of a plug higher in the rectum is characteristic of anacardium; a feeling of a lump, with pain in the rectum, is presented by sepia; as though the anus were closed, lach., plumbum; a feeling as though a lump or a plug were pressing out of the anus, croton; as though one were sitting upon a ball in the rectum, cann. sat., chima-philla; as though a heavy lump were in the anus, sil.; as though a lump were in the perineal region, therid.; as though a lump were wedged in between the os pubis and coccyx, aloe.—*Zeitschrift des Berliner Vereins Homœopathischer Ärzte*, xiv. Bd., Hft. v., 1895.

**ARSENICUM IODATUM IN TUBERCULOUS INFLAMMATION OF THE KNEE-JOINT.**—Dr. Puhlmann reports from the polyclinic of Dr. W. Schwabe, of Leipsic, the instructive case of a little girl, et. 3, of a so-called torpid scrofulous habit, who was pale and who could not walk on account of a chronic tuberculous inflammation of the right knee-joint. The affected joint was 3.2 cms. larger in circumference than the opposite one, the leg was held at a right angle, and on attempting to straighten it the little patient would cry out. Under various local (allopathic) measures, instead of improvement, a progressive aggravation had followed, and a swelling had appeared at the outer side of the knee, which seemingly contained pus.

In such cases, depending upon a scrofulous or a tuberculous base, there is no better remedy than arsen. iodatum, which the little patient received in the fourth decimal attenuation, 2 grains three times a day. She was also placed permanently in bed. From March 22d to April 30th, the swelling had nearly disappeared, the circumference of the joint was only 1.5 cms. greater than the other, the painfulness had decreased, though the articulation was still at a right angle. The remedy was continued, and a few grains of sodium silicum 3x, which remedy is more easily absorbed than silica itself, was added, to be taken in conjunction every evening. Nothing was heard of the case until September 30, 1895, one year and five months later, when the child, entirely restored to health, ran joyously around the room without the least sign of lameness. On examination, the joint was found about a centimeter larger in circumference than the other, but freely movable and painless. The whole right limb was smaller than the left.—*Leipziger Populäre Zeitschrift fuer Homœopathie*, Nos. 21 and 22, 1895.

# THE AHNEMANNIAN MONTHLY.

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REASONS FOR BELIEVING THAT THE SYMPTOMS IN DISEASES ARE THE EVIDENCES AND EXPRESSIONS OF NATURE'S EFFORTS TOWARDS HER OWN CURE.

BY D. W. ROBERTS, M.D., OWATANNA, MINN.

By *nature* is here meant the vital principle, or perhaps more properly, the vital force of the system. Our first effort in this investigation will necessarily be to obtain clear and correct ideas in regard to the scope and character of this vital force, and the laws that control it.

The physical forces, such as gravity, cohesion, chemical or electrical attraction and repulsion, belong to inorganic as well as to organic matter. We understand something of the laws by which these forces are governed. Vital force is found to differ very widely from either of these. It has no power over matter except within the living organism; but here its power exceeds that of all other forces, dominating and controlling them apparently to suit its own purposes.

As the most prominent and obvious law of the force of gravity is its tendency to hold masses of matter to the earth, so the most prominent and obvious law governing vital force seems to be, to build and sustain such *forms* as are peculiarly adapted to

each individual organism—this law applying to all the internal mechanism of the body as well as to the external form. In accordance with this law, it will be seen that all organic forms have their growth and are sustained by means of a most wonderful system of involuntary attraction and repulsion, having for its grand central object the most perfect external form of its kind, and such internal mechanism as may be required for the greatest possible harmony and health.

Since the laws of time are such as to necessitate constant change and waste, the growth and continuance of organic bodies must depend upon a system of unceasing nutrition and excretion, and this, of course, can only be accomplished by the vital force in accordance with its own peculiar laws of attraction and repulsion. As food is taken into the system the requisite nutriment must be eliminated from the mass, properly prepared, and carried to every organ and tissue of the body as their needs may require, while, at the same time, all innutritious or waste matter is conducted out of the system in various ways and by different routes. If the vital force be overtaxed by the introduction into the system of any very unusual amount of waste or toxic matter, disease must be the result. Or if any of the outlets be closed, such as the pores of the skin by sudden chill, so that the effete matter thus fails to be excreted, we have the same result—disease; but the cause in either case is found in material substance and not in any dynamic agency. The vital force also remains intact and true to its grand purpose, that of restoring harmony and health to the system.

A smooth sheet of water moving down an inclined plane, may have the tranquillity of the current interfered with, and all the placidity of the surface broken up by the presence of obstructions, but the force of gravity will remain the same, and will continue, if possible, by other routes, the downward course of the stream. Just so with vital force; neither its purpose nor its intrinsic power can be interfered with. It still remains the same active force, with efforts directed toward harmony and health, just as promptly and as surely as is the force of gravity directed toward the centre of the earth.

During health every part of the body evidently has its proper proportion of vital force; sufficient for all the involuntary work required, and besides this a large supply usually awaits the vo-

lition of the individual; but when any part becomes overtaxed or diseased, a new arrangement or distribution of force must take place, and often the surplus must be heavily drawn upon, and in this way many *symptoms* are produced. For instance, if a large amount of vital force be required for the removal of some poison, for the opening of closed conduits, for the replacement of destroyed or injured tissue, since the surplus energy must be diminished, the patient will become weak and desire to lie down; the stomach, lacking digestive power, will refuse food, and the mental faculties become obtuse. Now all of these we recognize as important symptoms, and they are directly consequent upon the vital curative effort. Again, suppose a deficiency of power to remove the trouble still remains; this intuitive vital force may have to put on more steam, increase the circulation and the temperature, and thus add two more important symptoms. There may also be local pains and discomfort not caused by any obstruction or injury, but by nature's effort to remove the trouble whatever it may be, and to restore harmony.

Pain may serve the vital force in a two-fold manner: First, to give alarm or warning of danger; and second, by actual curative symptoms, to show the diseased condition, and what the true curative effort is on the part of nature, and *should be* on the part of man. When we think of this matter, philosophically, it will be difficult to conceive of any other source of pain than that of the vital principle, or nature, in her efforts to protect and save the physical system. It should be remembered that the province of vital force reaches out in a manner altogether different from any physical force. For instance, in its tendency to produce horns, fangs, or stings, for defence against anticipated or possible external enemies. On this same principle, pain becomes a safeguard against self-mutilation and suicide. It stimulates to self-defence, and, in case of disease, it informs of the mischief going on, and at the same time, of nature's methods in her curative efforts, and it thus stimulates to intelligent aid, and should assist in the selection of appropriate remedies.

When the hand is held too near a fire, pain is quickly felt. In such case, the first pain seems rather for the purpose of alarm, and the hand involuntarily shrinks from danger; but, if the part

be actually burned, then the vital force, in its efforts to cure, causes a peculiar pain, and, if the hand be gradually placed nearer and nearer to the fire, nature will thus be assisted, and, though the pain will be increased, yet, if tissue is not already destroyed, the burn will at once be healed.

In keeping with the wonderful intuition everywhere observed in vital force effort, we not only have instantaneous notice of danger, when, from avoidable causes; but, where these causes seem to be unavoidable or overpowering, no pain is felt until the great danger is past and curative effort commences. The destructive agencies often get in their work several minutes, and sometimes hours, before the vital force commences its work of repair, and during this time curative symptoms such as pains are not observed.

When I was a boy, I had the misfortune to be drowned. Several of us, small boys, that could not swim, were bathing in a river. The water was warm and pleasant, and we amused ourselves by trying which could wade farthest into deep water, and I happened to step off from a ledge. Though completely under water, I was not in the least alarmed, but held my breath feeling sure that I could soon walk back to the shore. Instead of this, I must have walked into deeper water. I well remember all my thoughts and feelings at this time. I held my breath as long as I could, expecting to be strangled whenever compelled to breathe the water; but, to my great delight, I found that breathing water gave no pain whatever. For awhile, my mind was perfectly clear, and all my thoughts and sensations continued to be of the most pleasing character until, mid happy dreams, I fell asleep. Resuscitation brought all the struggles, aches and pains, because the vital force was now encouraged to try to save the system.

Dr. Heim, who met with a terrible fall of more than one hundred feet, upon the Alps, says that during that fall his mind was perfectly calm and clear. He thought rapidly but coherently. He says: "During the whole duration of the fall consciousness never left me. Without feeling the least bit embarrassed or frightened, I reviewed my situation and the future of my family. I heard distinctly the dull noise produced when my head and back struck against the different corners of the rock; I also heard the sound it gave when my body bounded

against the snow-wall; but in all this I felt no pain; pain only manifested itself at the end of an hour or so."

Now, in all such cases is it not plain that the reason pain is not felt sooner is because the vital force would do no good to caution or give alarm, and it has not yet commenced the work of repair? Whenever that work does commence, we have plenty of symptoms giving constant notice of the progress towards a cure and of the aid required.

I feel quite sure that all those little things we so often notice in our patients, and especially those that are unusual or peculiar, such as are so highly esteemed by the homeopath for their assistance in the selection of remedies, will always be found, whenever traced to their cause, to be symptoms that either show direct curative effects or that indirectly show something unavoidable in and caused by nature's plan of cure. Let us suppose that effete matter is prevented the usual external egress by a chill. Now watch, in the mind's eye, the possible disposition of this. See how the vital force will manage to get rid of it. The mucous membrane of the air-passages may be selected as the most feasible route and we have as consequence coryza, catarrh, sore throat, bronchitis, etc., as the vital force requirements and the local conditions may determine. If the stomach and bowels be especially chosen we may have nausea, vomiting, indigestion or derangement of the bowels, and from all this the kidneys may be called upon to eliminate more acrid matter than usual and, as a consequence, some of the urinary organs become sensitive or inflamed. Scores of symptoms, it will be seen, may thus arise either directly or indirectly from nature's curative efforts; but, knowing that her intuitive plan must be along the most feasible line, we select a remedy that will produce similar symptoms, and thus we unmistakably assist in the cure.

Another reason for believing that the symptoms in disease are caused by the curative efforts of the vital force is that, if true, it dissipates the mystery of the law of similars. Many of us have had abundant practical evidence of the truth of this law, but do not feel satisfied without some rational explanation. Our acknowledged leaders, writers and teachers have nothing new to offer, but constantly refer to Hahnemann, whose theory, in brief, is that diseases and drugs alike have

dynamic power, that the dynamic drug-force is more powerful than that of the disease; and thus he proceeds to account for the law on the principle that the stronger force will obliterate the weaker similar force. As illustrations of the universality of this law such examples are given as the light of Jupiter being obliterated by the stronger light of the sun at daybreak; the effects of disagreeable odors banished by taking snuff; the cries and shrieks of war unheard on account of the fife and drum; mourning and sadness relieved by the intelligence of some greater evil; the spirit of liberty aroused in slaves by extreme tyranny.

Now, I ask in all candor and with a sincere desire for the prevalence of truth in medicine how can this be accepted as sufficient explanation of our great law of cure? If, however, the idea of curative symptoms be true, if the vital force does produce symptoms as herein claimed, and if such can be fully proven, then, in a very plain and simple manner, we think the homœopathic law of similars can be accounted for. Surely we will at least have established a rational basis upon which a much better and grander medical superstructure may be reared. We, therefore, add this reason also to the other reasons for believing that the important symptoms in disease are but the evidences and expressions of nature's efforts to restore harmony and health to the material system.

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### IRITIS.

BY HALTON I. JESSUP, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

In all probability, more than half the cases of iritis that develop are first seen by the general practitioner. It is owing to this fact that a paper on inflammation of the iris may be considered as pertinent in such a meeting as this.

We must remember that the iris and ciliary body are very intimately connected, the iris being practically a continuation of the ciliary body, and being supplied by the same bloodvessels.

It is owing to these facts that we very seldom have a case of

simple iritis or cyclitis, it usually being the case that both iris and ciliary body are inflamed.

We will consider, however, the simple iritis, as I believe that in many cases if the patient has the benefit of intelligent and vigorous treatment, the ciliary body can be prevented from taking any appreciable part in the inflammatory process.

Iritis is always preceded by a condition of hyperæmia of the iris, which is characterized by change in color of the iris—a gray or blue iris becoming greenish, while a dark iris shows less pronounced change, but still, a comparison with the iris of the sound eye will show an appreciable difference. Often in this stage of hyperæmia we can see, by the aid of a magnifying glass, the engorged bloodvessels, which show as red streaks or small spots. As the body of the iris is made up principally of bloodvessels, we must expect that the engorged condition of these vessels will render the iris abnormally rigid, and, as a consequence of this, that the pupil will be contracted, and react but slightly, if at all, to light. Another factor which helps in producing the contraction and immobility of the pupil is a spasm of the sphincter produced by the irritation caused by the swollen iris tissue. In addition to the above symptoms, we have injection of the ciliary bloodvessels, marked photophobia, and the tears are abnormally abundant.

If seen and treated properly at this stage, I believe many cases of iritis could be prevented.

The onset of inflammation of the iris is characterized by exudation either into the iris or the anterior or posterior chamber. The exudation into the iris results in still further changing the color and in a general blurring of the markings of the iris. In fact, there is sometimes formed a membrane which covers the anterior surface of the iris. *Exudation into the anterior chamber* results in making the aqueous humor appear turbid, and thus gives to the pupil a grayish color. This color, however, is not always due to the turbidity of the aqueous, as sometimes the exudate deposits on the anterior capsule of the lens, becomes organized, and uniting with the exudative membrane on the front of the iris, results in one broad membrane, which covers the iris and pupil. This is known as occlusion of the pupil. The only bad result it is apt to produce is great impairment of the acuteness of vision. *Exudation into the posterior chamber*, in

uncomplicated iritis, results generally in adhesions taking place (at the points of exudation) between the posterior surface of the iris (near its pupillary edge) and the anterior capsule of the lens. Remembering that the pupillary edge of the iris is in contact with the lens when the pupil is normal in size, we can very readily see that a broader band is touching the anterior capsule in iritis, due to the contraction of the pupil. It is, therefore, a certainty that there will be formed adhesions between the iris and capsule during the stage of exudation, unless we can by some means draw the pupillary edge of the iris away from the lens capsule. These adhesions, known as post-synechiaæ, cannot be diagnosed with certainty in many cases till we have made use of a mydriatic. By the action of this mydriatic those portions of the iris which are not adherent to the lens capsule will dilate, while those points which are adherent will remain fixed. Consequently we get a pupil which is irregular in shape, having one or more pointed projections sticking out toward the centre of the pupil. The points of these projections are dark brown in color, due to the fact that it is the pigment layer on the posterior surface of the iris which is adherent, and the added fact that the anterior surface of the iris dilates somewhat under the action of the mydriatic. Thus, we have the posterior surface of the iris slightly everted at the pupillary edge. It is possible—and, unfortunately, it sometimes occurs—that, instead of isolated spots being adherent to the capsule, we have an adhesion of the entire pupillary edge of the iris to the capsule—this being known as *annular post-synechia*. In this condition we have the posterior chamber entirely shut off from the anterior, thus interfering with the circulation of fluids between the two. This condition is very dangerous to the eye, although the sight at first may not be at all impaired. The great danger is an increase in the intraocular tension, with all its consequent symptoms—in fact, a secondary glaucoma.

It was formerly thought that the existence of post-synechia tended to produce recurrences of iritis. It is now pretty well established, however, that such is not the case; and it has been quite well proven that it is only in those cases in which iritis manifests itself as the result of a constitutional disease that we are apt to have recurrence.

All through the stage of exudation we have pain, which is

referred not only to the eyeball but to the temple, occiput, and side of face even. Often with this pain there is attendant vomiting. One characteristic of the pain is that it is very generally worse at night.

Iritis is caused by either a general constitutional taint or by local causes. Thus we have syphilis, rheumatism, scrofula, gonorrhœa, diabetes and acute infectious diseases among the constitutional causes, while locally iritis may be idiopathic or the result of traumatism.

With regard to the treatment of iritis, the first thing to be thought of, is not the internal remedy, but to *dilate the pupil*. This is of the very greatest importance, as upon this point often depends not only the eyesight, but sometimes the saving of the eye from total destruction. It is therefore advisable, even in the stage of hyperæmia, to make use of a solution of the sulphate of atropine. This is used generally three times daily, and in a solution of the strength of 4 grs. to  $\frac{3}{5}$ j. If this does not succeed in tearing loose the posterior synechiæ and dilating the pupil, we may even go so far as to use a 10-grain solution every three hours. I have found it a very good plan to use, in stubborn cases, a 10-grain solution, putting three drops in the eye (at five-minute intervals) morning, noon and night. The action of the atropine seems to be increased by making use of hot fomentations for half an hour before its employment. It is a well-known fact that in patients past the age of thirty years, atropine must be used with care, as in some few instances glaucoma has undoubtedly been produced by its abuse. It is not dangerous, however, but absolutely essential, to use it whenever we have the symptoms of iritis, and particularly if we are sure it will be safe to use when the pupil is contracted and the tension of the eye normal. Of course, in its use we should always be on the lookout for any evidence of its physiological effects, such as flushed face, dry throat, crying out in sleep, drowsiness or stupor. If any of the milder symptoms arise, we must discontinue the use of atropine. If stupor comes on, it is generally sufficient to inject morphia.

To allay the pain, hot fomentations are generally all that is needed, making use of them as freely as necessary. Alternating the moist heat with dry is sometimes very effective. Leeches to the temple or the subcutaneous injection of morphia in the temple, are only called for in the most stubborn cases.

While other remedies may be indicated occasionally, I have never had to go outside of rhus tox. or some form of mercury. Rhus is especially useful in iritis of rheumatic origin, although I have seen even cases of this kind in which rhus did but very little, and mercury was resorted to with benefit. *Merc. iod. fluor.* has proven the most useful in iritis occurring early in the secondary stage of syphilis, when the mouth is dry. This remedy I have given in the 2x to begin with (one tablet (=  $\frac{1}{100}$  gr.) every three hours), and increased the dose to the 1x, one tablet every three hours or oftener. *Merc. iod. rub.* is probably the most often indicated remedy in iritis. Its best sphere of action seems to be in those cases of iritis occurring later in the secondary stage of syphilis, with an abundant flow of saliva. *Merc. iod. rub.* is given in the 2x, one tablet every three hours. If the iritis does not rapidly improve, we should then push the red iodide even to a mild salivation if necessary. I have, in several cases, given of the 1x of this form of mercury two tablets (representing  $\frac{1}{5}$  gr.) every three hours for several days before any increase in the flow of saliva was produced. In many cases the great secret of success is to push the mercury and atropine.

It has unfortunately occurred that cases of glaucoma have been mistaken for iritis, and atropine has been used, with the result of total destruction of the sight. If we bear in mind the following facts, however, such a mistake cannot be made. In iritis the pupil is *always smaller than the normal pupil*, the *cornea is sensitive to touch*, and the *intraocular tension is normal*. In glaucoma, however, the *pupil is always larger than normal*, the *cornea is more or less insensitive*, and the *tension is increased*.

If we make a careful examination to determine which of these two groups of symptoms are present, we will be sure not to make a mistake which would be very serious.

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#### THE ELECTRIC CENTRIFUGE FOR MICROSCOPICAL EXAMINATION OF URINE.

BY CLIFFORD MITCHELL, M.D., CHICAGO.

ONE advantage not yet sufficiently appreciated, which use of the electric centrifuge gives us is the facility with which sediments containing great bulk of amorphous urates are examined.

Ten years or more ago, Méhu noticed that urate sediments hid from view tube-casts, epithelia, spermatozoa, and other objects, and proposed addition of a solution of sodium phosphate so as to dissolve the urates. But with the centrifuge this is unnecessary. Procure a sample of urine of a woman and find vaginal epithelia in it. Next set the glass in a cold place until it is cloudy with urates. Examine again and notice that the vaginal epithelia, before so easy to find, are hidden wholly or in part by the granular urates. If now, however, the cloudy urine be taken and poured into a sedimentation tube of the centrifuge, the tube held in hot water until the urine clears, then placed in the centrifuge and revolved, say at a speed of 1700 revolutions for a few minutes, the resulting sediment if examined *at once*, is free from urates, because it has not had time to get cold, while at the same time the drop examined under the microscope is not yet warm enough to produce blurring, from condensation of moisture on the glass, hence a cover glass may be dispensed with. The vaginal epithelia originally found are now found again, and are far more numerous than if the centrifuge is not used.

The experiment as described above merely shows the possibility of successful examination of a sediment within less than five minutes of the time after a urate sediment in it was cleared by heat. A still more satisfactory demonstration, however, of the utility of the centrifuge, may be made by waiting until a sample of urine of a woman is obtained, which on cooling, at *ordinary* temperature, becomes clouded with a bulky, mealy sediment of urates, such as often is found in the concentrated urine of fevers or in gastric disturbances. In such urines one sees little or nothing but granular urates, but by procedure as before, urates may be cleared by heat, the tube set in the centrifuge, sediment free from urates obtained, and a large quantity examined for casts, corpuscles, and epithelia, with or without covered glass, the finding of vaginal epithelia demonstrating the absence of urates, and the whole being accomplished a minute or two before the urine grows cloudy again.

In conclusion I wish to say that my centrifugal work is done with the Purdy machine and that the medical profession should realize that we owe to Dr. C. W. Purdy, of Chicago, a debt of gratitude for introducing into urinary analysis the greatest improvement of the nineteenth century.

**THE DIAGNOSIS, PROGNOSIS AND TREATMENT OF ALBUMINURIA OF PREGNANCY.\***

BY G. MAXWELL CHRISTINE, M.D., PHILADELPHIA, PA.

THE three papers of the evening are not theses designed to contain the results of extended research, nor are they intended to contribute anything new to the facts already in the possession of the profession. The purpose is that these papers shall bring together in small compass the leading thoughts on the subject of albuminuria of pregnancy, so that those who feel inclined can use them as a basis for more extended inquiry. This paper naturally follows the two papers already read, and which have dealt with the ætiology and pathology of albuminuria of pregnancy.

However sure the obstetrician may be of his ætiology, and however correct he may be in his pathology, there is yet the very serious problem of treatment before him for solution. It is to furnish some aid in this solution that this paper is written.

If what is here said will in any way assist in the determination of a more certain prognosis respecting any given case of albuminuria of pregnancy, this paper will have subserved a good purpose. It has not been many years since the theories as to the causation of this disease or complication were bathed in mystery. Treatment was then purely empirical; now, as the ætiology of albuminuria of pregnancy becomes matter of more definite knowledge, treatment becomes more rational, and success is more certainly attained.

Diagnosis is the great prerequisite to the successful treatment of albuminuria of pregnancy. It is particularly necessary in this class of cases that the diagnosis should be made early; for it is possible to carry a case which has been diagnosed in its incipiency, through to a satisfactory termination, which, if allowed to gain any headway, would either be difficult of cure or prove quickly fatal. The lives of many women and of many unborn babes have been sacrificed by reason of

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\* One of three papers read before the Homœopathic Medical Society of the County of Philadelphia.

the sudden manifestation and fatal termination of symptoms of albuminuria in the pregnant woman, it being true with many of them that the condition had not even been looked for until too late for treatment to be of avail.

In assuming the responsibility of conducting a case of pregnancy to a successful issue, the accoucheur entails on himself a duty which, I fear, is not properly appreciated by all; for in many of the essentials that go to make up an ideal obstetrician many are wanting. This deficiency is not only that of ignorance and carelessness, but consists in good part in a too vague and ill-defined notion of what the duties of the accoucheur to the woman in his charge are. The too common error holds good that the only skill necessary on the part of the practitioner is during the actual birth of the foetus, and he neglects to appreciate that his skill and knowledge are just as much a necessity during the nine months of the woman's carrying, and the few weeks after her delivery, as when she is in labor. If this conception of the accoucheur's duty were more generally observed, obstetrics would be freed from much of its bitter consequences.

Let me now outline, in a concise manner, a few of the duties the accoucheur should carry out from the time he is engaged for the case until he can conscientiously discharge his patient as no longer requiring his attention.

*First.*—Women should be impressed with the importance of placing themselves when pregnant in the hands of the physician at the time when pregnancy is suspected or assured.

*Second.*—The physician should make careful inquiry into the history of the patient, and, if he wishes to be methodical, he will place the history so elicited upon a record-sheet—a most excellent form of which is supplied by the New York Pharmacal Company. These sheets contain spaces for filling in information upon all essential points respecting pregnancy, confinement, puerperium, condition of the child, etc. These record-sheets can be filed away for future reference, and to an obstetrician who expects to practice his profession for any length of time they will be found of great value if he should be again employed to render similar service to his patient.

*Third.*—This inquiry should have special reference to kidney and heart affections and to any symptom in former pregnancies

or labors which may have relation to kidney or heart insufficiency, whether organic or functional.

*Fourth.*—The patient should have her pregnant condition explained to her, particular attention being given to her habits, dress and eating. This explanation can be given concisely, but it ought to be of the most emphatic character—the consequences of a non-conformance with every injunction being fully portrayed.

*Fifth.*—The patient should be given to understand that the physician is the source from which she can gain the knowledge so essential to her, and she should be encouraged to come to him with questions about her pregnancy which she may wish to have answered, and not rely upon nor trust every neighboring woman whose advice may be plentiful, but not always valuable; in fact, the pregnant woman should make a confidant of her physician, and to him she should freely make known her complaints, that he may always know her condition and be ever ready to treat any abnormality which may present itself. This reciprocation between patient and physician may seem to some not quite so important as is here pointed out it is, but to the thoughtful and to those who realize the responsibility attached to the duties of the conscientious accoucheur, these directions will appear none too exacting.

*Sixth.*—Among the directions given the pregnant woman none can be of more importance—more than this, none of so much importance—than that she should report to him, as soon as she notices them, any of the symptoms indicating albuminuria or other forms of kidney disease. She need not be given a lecture on the subject, but she ought to be told, in a few words, what symptoms she must be on the lookout for; and if she happens to be a woman of good sense and sound judgment, she can be made acquainted with their full import. In this matter, as in everything else, the physician will be guided by the character of the woman he has to deal with; some are too nervous to be told much, in which case the husband is to be taken into the confidence of the doctor, and asked to keep watch over his wife for adverse symptoms. Every woman ought to be apprised of the fact that pregnancy often brings with it risks which, if not provided against, may prove serious, but that the danger arising from them may, by co-operation

between physician and patient, be reduced to a harmless minimum. The tact of the physician will suggest to him the language in which to express his views, and if he has successfully impressed them on the minds of those concerned, he will find not only co-operation but appreciation.

*Seventh.*—In the early months of pregnancy up to the sixth, and, if possible, up to the time labor sets in, systematic examinations of the urine should be made, and with this in view, the patient must be urged to send to the physician specimens of urine at stated intervals, say every two weeks. The first and fifteenth of the month are two dates easily remembered. It is a good plan to get a sample of the all-night's urine and one of the day's urine. It is not always easy to get this last direction observed, but it is rare to get a patient who will not send one sample. If the urine is not forthcoming at the dates agreed upon, the physician had better show his interest in the case by sending for it.

These seven directions are very important. The laity are beginning to recognize their importance, and I have heard of physicians who have been taken very much to task by observant patients for not paying attention to these very details.

Let me now proceed to a consideration of the differentiation of the various causes of albuminuria in pregnant women, for the success of our treatment depends largely on our knowledge of the cause. The following questions are important in this respect:

1. Whether the albuminuria is consequent on the condition of pregnancy, or on some condition antecedent to pregnancy.
2. Whether, if due to pregnancy, the albuminuria is organic or functional; and if functional, the exact cause of the altered function; if organic, the situation and character of the lesion.

These questions on diagnosis open up a wide field of inquiry, too large, indeed, for this paper; but it is hoped they will be fully entered upon in the discussion.

Of course, the great desideratum in diagnosing albuminuria is to detect the albumin in the urine. If the patient has been properly kept under observation, this substance will not have appeared for more than a short time in the urine before being discovered. Albuminuria is generally slow in manifesting itself, and usually plenty of time is given for its detection if the

examinations are made at the intervals mentioned. Though albuminuria is mostly a disease of the later months of pregnancy, women are not always exempt from it early in pregnancy. It is wise, therefore, to be on guard for it all through the pregnant state. The seventh month is the most common month for albuminuria to occur, and from this time to the end of pregnancy the patient should be kept under special surveillance. The fact must be borne in mind that though albumin is absent from the urine one hour, or day, or week, or month, it may be present the next. It may be present in the morning and not in the evening, and in the evening and not in the morning.

It is hardly necessary to state the tests that are used for the detection of albumin. No very refined tests are necessary, it being sufficient to know that albumin is present or absent, together with an approximation as to quantity. The heat and acid tests are the most practical, and what these tests will not detect is not worth considering. In using the heat test, care should be exercised that, before heating, the urine should be filtered and about two drops of acetic acid added to each three drachms to make it acid. For the nitric acid test, the urine should first be filtered and then warmed with one-fourth its volume of liquor potassæ before the acid layer is added.

In determining the percentage of albumin in the urine, the specimen should be taken from the whole day's urine. Esbach's albuminometer, for the quantitative estimation of albumin in the urine, is a ready and efficient apparatus. It may be safely considered that the gravity of the case is proportionate to the quantity of albumin found in the urine; hence the necessity for some means for the measuring of this substance.

Having determined the presence of albumin and its percentage, the next thing to do is to decide as to whether the disease is organic or functional. The microscope must now come into use, and an examination be made for tube casts, pus, etc. If there is no microscopic evidence of organic disease, the albuminuria is likely functional. I say likely, for too much dependence must not be placed on the fact that there are no microscopic evidences of organic disease. Some authorities believe that when albumin is present in the urine and its origin is renal, there must be some disease in the kidney responsible for it. It is admitted that there is such a thing as functional albuminuria,

but it is fair to assume that when functional albuminuria persists, renal organic changes must sooner or later follow.

If the disease is renal and organic, of what form is the renal disease? Is it peculiar to the pregnant state, or is it entirely independent of it except in so far as pregnancy has aggravated it? Though it may not be possible at all times to answer these questions, yet every effort should be put forth to do so.

While this paper has to deal with albuminuria only, uræmia is so closely associated with it that an examination as to the percentage of urea in the urine ought always to be made. A careful and even a hurried examination for urea will often solve the meaning of symptoms not to be otherwise understood, and if Doremus's apparatus for the rapid estimation of urea be employed, every practical purpose will be subserved.

In Philadelphia, the City Bacteriological Laboratory is open to every physician for the examination of urine. All that is necessary is to send a sample of fresh urine with the request for an examination. A report will be mailed the physician within a few hours.

Since urea is believed to be a very important element in the causation of eclampsia in pregnant women, there is no further need here to insist on physicians coupling with their examination for albumin one also for urea.

In the form of albuminuria of pregnancy not dependent on any cause but that of pregnancy, being due simply to a reflex from the gravid uterus, or as the result of a direct irritation, the amount of albumin is variable, from a large percentage to a mere trace. It is to be remembered that the ordinary albuminuria of pregnancy, in which the lesion is mostly tubal, can pass on to a chronic nephritis by aggravated attacks in repeated pregnancies.

Lusk is very clear, I think, when he defines the albuminurias of pregnancies as of three forms: transitory; nephritis, so-called, of pregnancy; and an aggravated pre-existing nephritis. The following is a synopsis of his thoughts on the subject:

*Transitory.*—Occurs in the later months; eclampsia apt to occur; hyaline casts and sometimes granular casts; disappears after labor. This form does not generally occur in subsequent labors.

*The Nephritis, So-called, of Pregnancy.*—Begins early in preg-  
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nancy; few casts; small percentage of albumin; heart distressed, being too forcible; altered placenta; some œdema; death of foetus; recurs in subsequent pregnancies; resembles, in early stages, an acute lesion, later a chronic. It is often, in all probability, a parenchymatous change, and blood, as a rule, is absent from the urine.

*An Aggravation of a Pre-Existing Nephritis.*—The woman has a chronic interstitial or parenchymatous nephritis before her pregnancy, which is aggravated into an acute form by reason of a reflex contraction of the arterioles of the kidneys, producing anaemia of the unaffected portion. The venous congestion is due to cardiac insufficiency. Casts and albumin are present in abundance. There are œdema and albuminuric retinitis, and there may be nasal and brain hæmorrhages.

**PROGNOSIS.**—The prognosis of albuminuria of pregnancy depends on several contingencies, among them being the following: The character of the albuminuric lesion, whether it is organic or functional, the state of the heart, and the complication or not of a pre-existing nephritis. The history of the case, prior to pregnancy, will often assist in determining these points, and much effort should be expended to bring them out. The prognosis affects both mother and child, the mother being disposed to eclampsia, abortion, premature labor, peritonitis, septicæmia, etc., and the child to death in utero, and the risks attending premature birth.

So long as albumin, even a trace, appears in the urine, and certainly so long as there are casts, nothing positive can be said as to prognosis. The manifestation of the symptoms of the disease will be a partial guide to an opinion as to the outcome of the case; but, too much reliance must not be placed on these, for, cases seeming to be progressing favorably, have taken a sudden turn with fatal results. The careful obstetrician will be somewhat guarded as to the prognosis he gives in any case, no matter how well it seems to be progressing. Eclampsia, whether albuminuric or otherwise, makes the condition all the more grave. Even after successful delivery, the nephritic disease or complication may persist. The prognosis is to be considered alarming if the urine is scanty, if the percentage of albumin is 75 per cent. or over, and if the quantity of urea is 50 per cent. of the normal down to a few grains in twenty-four

hours. Treatment, of course, affects the prognosis, and, in the light of modern methods, a better promise can be given of an ultimate cure than was possible forty or fifty years ago, when the condition was neither properly understood nor effectively treated.

**SYMPTOMS.**—The symptoms of albuminuria of pregnancy most commonly to be looked for are, dropsical conditions of the lower extremity and vulva, puffiness of the eyelids, vertigo, affected vision, palpitation of the heart, nervous irritability, headache, excessive nausea, and diminution in the quantity of urine passed in the twenty-four hours.

A pregnant woman is not necessarily a sick woman, though during the first two or three months of pregnancy, there are certain more or less constant derangements, which are regarded as physiological; and these may assume such an aggravated form as to make the life of the woman miserable. But these symptoms must be carefully distinguished from other symptoms which are not physiological, and which may have a serious import. While both classes of symptoms require attention and treatment, yet the one is comparatively innocent of serious harm, while the other may have a more serious meaning.

The pregnant woman may be uncomfortable from the load she carries, and the functions of certain of her organs may be interfered with, but on becoming pregnant, unless she be sick or constitutionally weak, she ought, other things being equal, to pass through her pregnancy with slight, if any, departure from her usual good feeling. Should she have headaches, spells of vertigo, more than ordinary palpitation of the heart, excessive or peculiar nausea or vomiting, swollen feet, etc., they should not be considered as a natural part of the pregnancy, and, above all, their cure should not be entrusted to nature. Nature often does a great deal for a pregnant woman in sometimes coming to her relief when distressed by abnormal conditions, but nature has a relentless foe in *albuminuria gravidarum*, whose consequences she can rarely combat or overcome. Hence, the importance of an early and positive interpretation of every one of the symptoms of disease the pregnant woman presents.

The first thought that comes to the mind of the physician when he gets a case of albuminuria of pregnancy is, whether

the albuminuria is the result of the pregnancy, and how can the effects of the pregnancy be overcome. He naturally wishes he could eliminate the element of pregnancy. He feels quite sure that if the pregnancy could be terminated the one great cause would be taken from the case, and the rest would be easy of accomplishment. The question then occurs, Shall the pregnancy be terminated? shall the uterus be emptied of the contents which, in all probability, constitutes the only serious factor in the case? By so emptying the uterus, we carry the case back to an ordinary renal affection, and very likely, in many cases, cure the albuminuria altogether, because we remove its cause. That it is necessary, in some cases, to do this there can be no doubt, though men competent to express an opinion have said, give them the patient early enough, and they will carry her through albuminuria of pregnancy without resorting to abortion or premature birth, and will bring her to the lying-in-bed with a live child. This is a very rosy-colored statement, and can be taken for what it is worth. Much can be done by treatment, if the case is seen early enough, and the patient can be made obedient to the physician's directions; but there are cases where the disease is not seen early, but has encroached beyond the power of remedies to be of value; in these cases, the question is forced on the physician, Shall I evacuate this uterus? It is probably safer to answer this question in the affirmative every time; if the symptoms are grave enough to warrant the question, they are likely serious enough to warrant the operation. It is, by far, easier to carry a woman through an abortion or premature birth, when done under proper conditions, than it is to bring her safely through an albuminuria of any considerable degree of seriousness.

Some of the points that will aid us in determining whether or not to empty the uterus, are as follows: A rapidly increasing percentage of albumin in the urine; a weakening heart; rapid loss of strength; great extension of anasarca; and threatened or occurring eclampsia. These will serve to indicate the urgency of the procedure. But, even with all these symptoms portending speedy dissolution, operation has often either been declined or advised against, and the woman has been delivered of a healthy child, and she herself has been cured without operation. Both sides of this question have been here presented,

because no absolutely sure rule can yet be given. As before stated, the seriousness of the case will usually indicate the operation, and the practitioner is acting wisely and safely if he recommends it, and, if necessary, insists on it.

**MEDICINAL TREATMENT—*Mercurius*.**—In the choice of a remedy for the treatment of either functional or organic albuminuria occurring in pregnancy, probably no remedy will claim so general an attention as *mercurius*. For one of the clearest expositions of the symptomatology of this medicine, the reader is advised to consult *Heinigke*, pages 347 to 353. This work is so valuable in respect of all the remedies which it treats, that I have made it my ready book of reference; and many of the symptoms given in this part of my paper have been taken from this work. The symptoms of *mercurius* have albumin in the urine, with epithelial and fibrous casts, epithelial cells of the tubuli being marked on the surface, these tubuli showing some signs of fatty degeneration. The urine is copious, finally being suppressed, and scanty. *Mercurius* is to be considered in all inflammations of the kidney where the urine is scanty and albuminurious. The best form of mercury is the corrosive sublimate. See, for a clear statement of this, *Heinigke*, page 355.

***Helonias*.**—Ranking next to *mercurius* is, perhaps, *helonias*. It is certainly very effective in indicated cases. It has albuminuria as a prominent symptom, but is to be restricted in the main to those cases where the urine is clear, light-colored and profuse, thus contrasting with *mercurius*.

***Apis*.**—This remedy has scanty, high-colored and albuminous urine, and œdema of the face and extremities.

***Arsenicum*.**—This remedy is indicated when the urine is albuminous, due to hyperæmia of the kidneys. Casts are abundant, and the quantity of the urine is increased. *Arsenicum* is useful in catarrhal conditions of the renal mucosa, and in catarrh of the bladder and urethra, with restlessness, prostration, anaemia and dropsical conditions.

***Glonoin*.**—This remedy is best in congestive conditions, where there is an increased flow of urine, albumin (due to hyperæmia of the kidney), heart and head symptoms of pulsation and quick-throbbing, frequent desire to urinate at night, rush of blood to the head, etc.

***Apocynum Cannabinum*.**—This remedy is suggested by the fol-

lowing symptoms, and when clearly indicated, is marvellous in its effect; dropsical conditions, slowly acting kidneys, urinary expenditure suppressed, weakness, depression, drowsiness and labored heart action. In doses large enough to produce the desired result, gastric distress is often caused; this can be overcome by uniting with the remedy a liquid pepsin.

*Lachesis*.—This remedy is indicated in dropsical conditions associated with albuminuria, where œdematosus tissues are disposed to be dark colored. The urine is dark and albuminous, and sometimes nearly black. The symptoms are aggravated after sleep.

*Terebinthina*.—Scanty, dark-colored urine, with blood and albumin present. This remedy is especially useful in acute congestion of the kidneys, rather than where there is an inflammation of them.

*Cantharis*.—Indicated in acute and recurring attacks of nephritis. *Cantharis* is not a specially albuminous remedy, but is useful in acute congestions or inflammations of the kidneys, and particularly in simple renal insufficiency with bladder symptoms.

*Helleborus*.—This remedy is useful where there is catarrh of the bladder and kidneys; the urine is scanty and dark, accompanied with bladder weakness. *Helleborus* is particularly appropriate if there are meningeal symptoms.

*Pilocarpine*.—This remedy has considerable repute, mostly with old-school physicians. There is some very strong evidence of its value in doses of grain  $\frac{1}{2}$  to  $\frac{1}{3}$ , administered hypodermatically on the average about once a week until no longer necessary. Its value is greatest, perhaps, in promoting diaphoresis in eclampsia. Respiratory and circulatory weakness prohibits its use unless in small doses.

*Uranium Nitrate*.—Not used as often as its symptoms warrant. It is a good diabetic remedy, and the nearer the symptoms of the patient approach those of diabetes, the more clearly is the remedy indicated. In those cases where acute parenchymatous nephritis is associated with diabetes, uranium nitrate will give brilliant results.

The above list of remedies does not exhaust the supply, for there may be complications which none of the above will reach; but, in the main, those mentioned will be found to cover the indications.

If the remedies which are given, and the various measures adopted for the alleviation or cure of the symptoms do not suffice, and the albuminuric symptoms increase to an alarming degree, then evacuation of the uterus is *the* resort. Once having determined to do this, the operation should be done forthwith. If time is given, it is wise, for several reasons, to summon assistance and advice. The physician wants advice, assistance and protection in this class of cases. It is needless to go into the details of the production of abortion and miscarriage. Of course, it must be done under aseptic conditions if possible. Having evacuated the uterus, the bladder having already been emptied, a purgative should be administered, and nothing is so good as calomel, with a drop or two of croton oil. This can be assisted by an enema of castor oil, epsom salts, turpentine and water. Diaphoresis is to be secured by means of an alcohol-vapor bath, hot-water bottles, etc. Pilocarpine, hypodermatically, will assist in this sweating process.

If the case is one of eclampsia, and the convulsions persist or threaten to return, chloroform by inhalation is to be administered up to the point of keeping the patient under its anesthetic influence. Chloral hydrate by enema has here a very happy application.

Usually, the evacuation of the uterus puts an end to the grave symptoms, the eclampsia ceases, the kidneys become soon restored to their normal function, and the patient recovers. This is not always the result; sometimes the albuminuria continues, the convulsions recur, the patient becomes exhausted, and death soon ends the misery. If this result threatens the case must be carefully watched, and the appropriate remedies and measures adopted.

If the patient recovers, she should be kept under surveillance for several months until it is proven conclusively that she no longer has deficient kidney function.

The patient should be warned that another pregnancy may bring her the same array of symptoms, and for this reason pregnancy should be advised against. If she should get pregnant, she must be warned to place herself as soon as possible under the care of her physician.

## A CASE OF TYPHOID FEVER AND SOME OF ITS LESSONS.

BY W. S. SEARLE, M.D., BROOKLYN, N. Y.

(Read before the Homœopathic Medical Society of Kings County, N. Y.)

I AM just concluding the treatment of a case of typhoid fever, the history of which has afforded some lessons of interest and value to me for reasons which I will try to make obvious to you. A brief outline of its prominent features will suffice for my purpose, and will, therefore, be all that I shall inflict upon you. The patient is a girl of twelve years living on President Street, near the park, in a house the sanitary conditions of which are of the best. She is the only child of a widow, and as might be imagined, has every care possible. She returned from a summer in the Catskills about two months previous to the inception of the disease, and attended a private school near her home. In neither country nor city, so far as known, was she exposed to infection.

On the 25th of October I found her suffering from a condition of mingled chills and fever. It was associated with yellowness of the conjunctivæ, and her urine appeared to contain bile. The next day she seemed a little better, but on the succeeding, was worse again.

Typhoid was then suspected. The fever rose typically (two degrees up each night and one down each morning) until on the evening of the fifth day it reached 106°. About this time painful micturition suggested an examination, which disclosed on the left labium three gangrenous spots, from one half to one inch in diameter upon a dark-red infiltrated base. There was also constant coughing, hawking and spitting of a dark bloody mucus. The breath, urine, and flatus were very offensive.

It may be remarked here that throughout the entire course of the disease diarrhœa and abdominal distension were conspicuously absent. Indeed, if it had not been for a copious and typical eruption upon the chest and abdomen in the second week, diagnosis would have been difficult.

The gangrenous ulceration of the vulva, a similar spot in the mucous membrane of the lower lip, the exudation of blood

from the mucous surfaces and the yellow conjunctivæ, appeared to me to strongly indicate crotalus, and it was given in the sixth dilution.

Its beneficial effects were quite perceptible after a few hours. The gangrene ceased to spread, the bloody ptyalism became rapidly less, and the fever diminished. I will note here that, though a dry cough persisted, there never was bronchial nor pneumonic complications. Delirium was mild, and for one or two nights only.

Thus the case progressed until on the night of the ninth day there was a hurried call to stool, and she passed, with two or three soft faecal masses, about a pint of horribly offensive blood. As there was, and had been, no tenderness nor swelling in the right iliac region, I was inclined to believe that this blood had exuded into the colon, as it had been doing in the mouth. It seemed obvious, however, that crotalus had done all that it was capable of doing, and I substituted for it nitric acid in the first dilution.

From this drug we appeared to obtain quite as brilliant results as from that previously given. No further haemorrhage occurred, the foul odors rapidly diminished, disappeared wholly in two or three days, and the case lost all its formidable characteristics.

Bryonia had a beautiful effect upon the teasing dry cough that racked the head, and a few other drugs were intercurrently employed as they seemed to be indicated. But the rail fence of our fever chart daily and steadily sank toward the normal and convalescence began in the fourth week. The diet throughout was dilute milk varied only by a little meat jelly.

My first remark upon this case is that, in an experience of nearly forty years, I never saw one of worse promise, and my early prognosis was very grave. A poison that in a few days could seize upon a hearty, healthy child, besoul her pure sweet body till it stank like decayed meat, and even began to rot her flesh while yet alive, must have been virulent indeed.

Only the other day I called your attention to what I deemed the prognostic significance of foul emanations from the body in Bright's disease, and to the homœopathic treatment appropriate to such conditions. I failed then to note what I now do—namely, the confirmation which those views obtain from acute

cases of the sort just described. It will hardly be disputed that the virulence of many, and perhaps all acute diseases may be measured by the offensiveness of the secretions or excretions, and I think the same is true of many, if not all, chronic maladies.

I must remark that I was never more gratified by medicinal treatment. It almost seemed that for once, at least, in my life I was inspired (I say it reverently, for I believe that both doctor and patient are in the control of a higher power) to prescribe the right remedy, in the right dose, at the right time, and in a few hours the beneficent effect of each became apparent. The hypnotic state of the blood which allowed it to exude through the mucous membranes, and the gangrenous condition of the vulva, were quickly changed by crotalus, and permanently so, for they did not return.

The foulness of the excretions was corrected in a few days by nitric acid. Bryonia acted equally well, and, in short, not a drug was given that did not do all that could be asked or expected of it; and yet I desire you to note well this fact, the disease ran its full course in spite of all.

It will be remembered that in a late paper upon "What is Fittest in Homœopathy and Likely to Survive," I remarked upon the applicability of our therapeutic law in the treatment of the zymoses. I claimed that neither by this nor any other therapeutic formula could we cure a case of zymotic disease in the sense that we can and do accomplish that result when the disease is not zymotic.

I still hold this view.

As in the present instance, when specific germs produce congestion or inflammation or other pathological changes in tissue or organ, remedies homœopathically selected and administered are competent so to modify it or them as to change the tendency to death for conditions consistent with life. But, as is also illustrated here, we cannot hope in this way to destroy or render impotent causative germs. Nor can we shorten their lifetime. Only by what may be termed antidotal influences (if, indeed, such exist) can that be accomplished.

No physician by homœopathic means ever has or ever can limit the duration of scarlet fever, or measles, or small-pox, or gonorrhœa, or syphilis, or any other really zymotic disease.

They will run their course until we shall have discovered and can with safety apply some agent capable of destroying their causative germs. In a very few instances such agents have been discovered. We can, for example, kill or render innocuous the gonococcus, and thus abort the disease it produces. It is possible that in a few other zymoses we can accomplish like results, but that we shall ever attain similar safe antidotes or "microbe-killers" in all forms of disease is certainly unlikely.

A very interesting and important question suggests itself here. It is this:

Admitting the verity of what has just been said, is the converse also true? That is to say, supposing that, as a matter of fact, we can and do often, and, as a rule, cure a disease by administering drugs, under any therapeutic formula, such, for example, as pneumonia, stop its progress, arrest its course and bring the patient to a state of health much more speedily than would occur under the most favorable conditions in the known natural history of the disease, does not this clinical fact afford at least presumptive proof that such malady is not zymotic in character and origin?

Probably not one of us has failed to accomplish such a happy result in pneumonia, not once only but often, and even as a general rule, and yet eminent bacteriologists believe they have found microbes to which this and other diseases with which we have similar clinical experiences are confidently attributed as causative.

It seems to me that we must answer this question in the affirmative, and hold that clinical success in the one instance and failure in the other does afford strong presumptive proof, if it does not conclusively settle, the problem of zymotic or non-zymotic etiology in disease.

There must be some reason why we can cure a pneumonia, or a diphtheria, or a pleurisy, or a dysentery by the administration of drugs according to one or another therapeutic formula, and yet as a rule, and conspicuously, fail to thus dominate other diseases. Is it not because the one class is zymotic and the other not so?

I am aware that there are numerous instances where fevers that must be classed as typhoid or continued fevers, if classed at all, do not persist for more than one or two weeks.

But there is little doubt that the typhoids of one year, and even the typhoids of the same year, differ in their natural history. In other words, the life-term of typhoid germs is not invariable. I am aware, too, that some authors speak of abortive typhoids; but it must be remembered that the doubt of correct diagnosis always casts a shade over this abortive theory. For myself, I must express the conviction that cases manifesting the distinctive and characteristic eruption of this disease never abort with or without treatment—at least, I never saw one thus distinguished that did not run the well-known and classical course, in spite of all that was done to stop it.

I remark, further, that this case well illustrates the power and virtue of the homœopathic method in zymoses. It exemplifies what we can sometimes do, and what we could always do, for such patients if remedies were always as clearly indicated as they were in this instance. It must be confessed, however, that, unhappily, this is not at all times the case.

One other feature of this clinical history is interesting. Whence came the germs or poison in this instance? The mother, a lady of perhaps forty years, has never had typhoid. She was her daughter's constant companion during the summer and after their return to the city. They ate the same food and drank the same water. She nursed the patient, kissed her, bathed her, has been exhausted by lack of sleep and depressed by the most acute anxiety; but as yet she has manifested no symptom of typhoid, and it will be contrary to my experience if she does develop it.

None of the patient's fellow-scholars have been attacked, and, so far as I can learn, none of the neighbors who consume the same milk and other food have typhoid; in short, I am utterly at a loss to know where to look for the origin of the disease.

Still, this is not a unique experience. I know of an instance where, fifty years ago, a family with ten children lived in the outskirts of a little New England village. A severe winter shut them in so closely that they even had no letters for a long time. One of the children came down with scarlet fever, went through the disease typically, even to desquamation and subsequent nephritis. Antisepsis was unknown; isolation was not attempted. No other case occurred that winter in the entire

community, nor did one of the other nine, none of whom had ever had the disease, become infected.

Truly, there are "things in heaven and earth undreamed of in our philosophy."

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### THE DYNAMIC ACTION OF MEDICINES.

BY J. D. BURNS, M.D., GRUNDY CENTRE, IOWA.

In the December issue of the HAHNEMANNIAN my esteemed friend, Dr. E. M. Hale, has an article under the title, "Have Drugs a Dynamic Action?" This is in answer to some things I said in my address, published in the November, 1895, number of the HAHNEMANNIAN. I have read the Doctor's article over, very carefully, a number of times and I cannot see that he has thrown one particle of light on the subject he is writing about. Who can tell what the doctor's idea is on the subject under consideration, viz., the dynamic action of medicines, by what he says in his article. In the quotation I made from his book I thought it was plain that he denied that there is such a thing as the dynamic action of medicine. I can only judge of what a man means by what he says. According to his admissions, in his article, he says one thing in his book but means another. A general statement and a specific statement cannot be contrasted unless we can understand the exact meaning of the general statement. Now what does the doctor mean when he says, "medicines act on the animal organism by means of their ultimate molecules coming in contact with the various tissues of the body?" Now this is a general statement, and the natural supposition would be that he meant just what he said. The trouble is, it is too broad, so that at one time he can mean one thing and at another time mean another. But if we read a little further down on the same page, I think we can tell what he meant when he wrote his book. He says: . . . . "The medicines alluded to in the foregoing observations are of that class, principally from the vegetable kingdom, known as 'expectorants.' They are abies, ammon., etc. . . . All these drugs, when taken into the stomach, are absorbed, carried

through the system and excreted through the skin, urine, breath and faeces; but their main exits are through the bronchial and renal mucous surfaces. Those of the above that contain volatile or fixed oils . . . etc., can be discovered by their odor in the breath expired by the patients, even when given in small doses. *This quality makes them especially valuable, for, in passing out of the body, they pass through the diseased tissues and act better than if sprayed upon them."*

His special pleading here is, clearly and only, for the local contact of the remedy, unchanged from what it was when taken into the stomach, and we see that he holds that it is by medicines actually coming in contact with diseased tissues that they are curative. This certainly explains the meaning of the general statement above. In his explanation of the action of belladonna he makes the specific statement, that "it is not because the molecules come in contact with the tissues of the face that it is red, but because of the irritation of the vaso-motor nerve centres in the brain. Thus we see that his general statement may mean one thing, at one time, and quite a different thing at another time. He backs up his specific statement by the assertion that, "if we have a patient presenting the primary symptoms of belladonna, we know that the 6th or the 12th of the drug will remove them;" which is true. There must be more than one way in which medicine acts on the animal organism, or else one of these assertions is wrong, and there must be a link in the chain we have not seen.

He says: "The contraction of these vessels by the *secondary* action of belladonna, etc." How can we get the secondary action without this missing link, or unless the vitality of the part was primarily affected? The chain is broken and without this link, which is, *force, power, energy*, there can be no connection. The irritant cause, *peculiar to belladonna*, came in contact with the vaso-motor nerve centres of the brain and sympathetic ganglia and produced the effect of flushing the face and brightening the eye, by generating or setting up, *de novo*, a force or power that directed the nerve or vital force in such a manner that the capillaries of the face were dilated and the face became flushed all the way from a pink to a deep crimson, just in proportion with the amount of influence, more or less, that this force which was generated, *de novo*, had on the vital force of the

part. Now, I think, it is easy to explain the secondary action he has spoken of on the principle that action and reaction are equal and opposite, that force, power, energy, which, primarily caused the capillaries to dilate, in its reaction or opposite action caused them to contract and as a result the blood is driven out and the face becomes blanched.

Now is this action dynamic? I am convinced that a closer definition of what is meant by the expression dynamic action is needed, or at least what I understand and mean by it. I will first state what I do not mean by the term. I do not mean a power that is thought by some to be developed by placing a little of the tincture in a bottle with a limitless amount of alcohol and shaking or giving the mixture a "certain number of succussions to develop its dynamic force." Or an imponderable force resident in a drug independently or in the abstract. I understand the word dynamic to be of Greek origin from the word dynamis, which means power, force, energy, and which has its root in the verb dynamine, "to be able" and has the elements of action in it, so that "dynamics" is the science which treats of *forces* or *powers* in action. All will agree that in the human organism, the spirit-like power, force, energy, is the power behind the throne and is constantly in motion while life lasts, and any force or power which will act upon that force or power, either to excite, depress, accelerate or modify in any manner, acts dynamically. The question then would be, have drugs a power in them, which by their action on the organism develop a force, that will influence or act upon this spirit-like power or vital force? If they have *their* action is dynamic. We say they have and claim this is the only basis on which we can explain and on which the doctor explains, the action of belladonna. If I hit a man on the back of the head and in a few minutes he vomits or faints, what is the modus operandi? If I inject hypodermically the right quantity of apomorphia, in a very short time, he will vomit. What is the modus operandi? And what is the difference? I claim that their action is identical, so far as the stomach is concerned. The dynamite stick has a resident power in it, but it is not developed until the proper amount of force, either heat or friction, is brought to bear upon it. The dynamite, *per se*, is harmless, but the power developed by heat or friction will blast the stone. So it is with drugs on the shelf; they are harmless, but taken into the system they de-

velop a power that will not only influence but extinguish vital force.

The doctor says: "He evidently implies that there resides in belladonna a dynamic, imponderable force, which acts upon the nerve centres of the brain." I do not imply any such thing, but I not only imply but I assert that the poisonous element, the ego of the drug, belladonna, when taken into the system, from its action on the nerve centres and sympathetic ganglia, develops, *de novo*, a force or power that, in turn, effects or influences the vital or spirit-like force, and that this action is dynamic. But the doctor says: "I contend that he cannot cause these symptoms with belladonna above the second dilution." This statement begs the whole question. I might as well say, because a man can't lift a ton he can't lift a pound. Why of course we cannot produce as much of an effect with a lesser cause as with a greater. It would be just as consistent for the doctor to say that because the belladonna didn't kill the patient it didn't flush his face. He acknowledges that under certain conditions the 6th or 12th will influence the parts and even remove the ailment, or in other words, that it will restore lost equilibrium. Because the effect of flushing the face cannot be produced by belladonna, above the second attenuation, it is no proof that the parts are not affected. The tendency of the vital force to maintain an equilibrium is very great. Besides, the human sensibilities are too defective to take cognizance of so slight a divergence as an attenuation above the 2d may and does produce; but in the case of the 6th and 12th the doctor cites it as proof positive that they will produce a ripple on the sea of vital force, whose waves, once set in motion never stop until they reach the normal condition of equilibrium.

No, Doctor, I would not, for one moment, be understood as implying that you were ignorant of the modus operandi of the action of the drug; but, if I had entertained such an opinion, I would be forced to abandon it now, for you have demonstrated that you did understand its modus operandi and have acknowledged all we asked for, but in your acknowledgement you went squarely back on your own proposition, and the corollary to be deduced from it, viz., that drugs have a curative action on the human organism by virtue of the molecules of the drug coming in direct contact with the diseased tissues of the organism.

**A YEAR'S WORK OF ANÆSTHETIZING IN THE HAHNEMANN HOSPITAL CLINICS.**

BY J. W. HASSSLER, A.M., M.D., PHILADELPHIA.

DURING the past year beginning April 1, 1894, there were 695 cases anæsthetized. Before explaining the *régimé* through which each patient undergoes preparatory to the administration of an anæsthetic, I will cite the number of cases anæsthetized under each anæsthetic; the amount of each anæsthetic used; average quantity to each patient; the average time to complete anæsthesia; the number of hours each anæsthetic was used, and the average quantity in one hour.

	Ether.	C. and O.	Chloroform.
1. Number of cases.....	370	254	71
2. Amount used.....	87 lbs., 14 $\frac{1}{3}$	7 lbs., 1 $\frac{1}{3}$	2 lbs., 5 $\frac{1}{3}$ , 7 $\frac{1}{3}$
3. Average quantity to each case .....	8 $\frac{1}{3}$ , 8 $\frac{1}{3}$	4.43+	5.33+
4. Average time to complete anæsthesia...	7 min., 4 sec.	4 min., 22 sec.	4 min., 9 sec.
5. Number of hours used .....	264 hrs., 15 min.	166 hrs., 37 min.	26 hrs., 6 min.
6. Average quantity in one hour.....	5 $\frac{1}{3}$ , 8 $\frac{1}{3}$ +	6.73+	1 $\frac{1}{3}$ , 4 $\frac{1}{3}$ +

1 case of nitrous oxide.    2 cases of A. C. E. mixture.  
2 cases of C. and O. not fully reported.

The following *régimé* is then gone through in each case unless altered by the attending surgeon, or it being an accident case needing immediate operation. The day prior to the operation the patient is given a bath; at 2 P.M. a purgative, usually compound licorice powder, a drachm and a half to two drachms, a light supper of cream toast, soft eggs, fruit, coffee or tea. For breakfast at 8.30 A.M. on the day of operation they are allowed simply liquids as a cup of beef tea or coffee; all liquids are then restricted before operation. If they desire something to quench their thirst it is given in very small quantities. Six hours previous to operating, a plain enema, at the same time patient is catheterized and specimens are sent to the pathological depart-

ment for examination. A few hours before operation the anæsthetist visits the wards and makes a physical examination of each case, examining the heart, lungs and urinalysis sheet; questioning them in regard to past habits of using alcoholic drinks, also whether or not they have false teeth ; if so, these are removed. From these data he then makes his choice of the proper anæsthetic to administer. At the appointed time the patient is brought to the anæsthetizing room where they undergo another examination in regard to the protection of the body, as sufficient blankets, hot bottles, looseness of garments about the chest and neck. A few encouraging words at this moment are often needed to reassure the patient, the orderly standing by the side of the patient to help restrain them if they should resist too violently. After everybody in the room is quiet the administration is begun. As has been my practice, the inhaler is placed upon the face free from the vapor of the anæsthetic, allowing them to respire for a few seconds, when it is gradually administered, increasing it as the patient advances into the second stage and until anæsthesia is completed. During the operation the anæsthetist sees that the patient is well protected in parts not exposed for operation ; at its close the junior resident surgeon goes with the patient to the ward where they are taken care of by the nurse in charge.

The anæsthetist visits the cases anæsthetized before leaving the hospital; if not reacting properly, gives or orders to be given the proper stimulants. All liquids are restricted following the operation for a few hours ; this is to prevent vomiting. In regard to the different anæsthetics administered : Chloroform and oxygen have been given during the summer months and are still used in the Saturday clinics. In regard to the efficiency of the anæsthetic, Dr. Northrop reported it fully a few months ago, and I have had the same good results since that report. The percentage of cases having vomited following its use is but 9.5 per cent., occurring mostly in alcoholics and intestinal operations. The shortest time to complete anæsthesia was forty-eight seconds and the longest twelve minutes in a hysterical woman. The smallest amount used was three drachms in seventy minutes, cœliotomy for removal of both ovaries. Ether has been given more frequently. During the fall and winter months the students of the senior class admin-

istered the anæsthesia under the supervision and instruction of the anæsthetist.

The mode of its administration has met with good results. The Allis inhaler is placed upon the face, the patient respiring for a few seconds before the ether is begun; by so doing their confidence is gained. The ether is then started by a gradual dropping. This is increased as the second stage supervenes. By this method the irritation to the respiratory passage is lessened. The fact has also been noted that but 2 per cent of the cases manifest a second stage, except in alcoholics; by that I mean violent struggling, crying, laughing, etc. This dropping is continued until anæsthesia is complete, after which it is only administered when indicated. A number of times it was necessary to change from ether to chloroform, the patient resisting too violently. The shortest time to complete anæsthesia was two minutes and the longest fourteen minutes. Smallest amount recorded, one and three-quarter ounces in fifty-seven minutes.

In connection with ether I report a death during its administration. Girl, age 6 years; burn of legs; lungs and heart normal; urine trace of albumin; temperature 99°; pulse 114. Poorly nourished, nervous temperament, resisted violently the administration of ether; completed anæsthesia in three minutes; amount used four drachms. During cleansing of burns, spasm of glottis relieved by pressure on base of tongue; breathing and pulse became feeble, cone removed, sudden cessation of both respiration and circulation. Means of resuscitation by elevating foot of table, rhythmical and artificial respiration, dilating rectum, heat, hypodermics of agaracine mixture, atropia,  $\frac{1}{150}$ , strychnine,  $\frac{1}{30}$ , faradism, oxygen gas, failed, and after working a half hour, work was suspended. Post-mortem examination revealed perfect heart, lungs, spleen, liver and kidneys. Intestines showed inflammatory spots. Brain œdematosus, 2-3 ounces of fluid extra dural, ventricles filled with the same. Decision of the Coroner's jury was, "Death from nervous shock during etherization."

Chloroform has been restricted to children, alcoholics and in short operations. It has been my practice where there is to be a lengthy operation, and where small quantity of an anæsthetic is advisable, to give a hypodermic of atropia,  $\frac{1}{144}$  grain; morphia,  $\frac{1}{2}$  to  $\frac{1}{4}$  grain. Atropia acting as a stimulant to the res-

piratory and vaso-motor centres. Morphia as a partial narcotic, and, as Nussbaum observed, it deadens the sensibilities of the respiratory passages to such a degree that ether and chloroform vapors produce less reflex disturbances of the respiration and circulation. The pressure of the blood is also better sustained in the arterial system by its stimulating effect upon the contractility of the arterial coats and upon the motor ganglia of the heart.

A few words in regard to the restoratives used. They have been very sparingly administered on account of their causing excessive reaction when too freely used, except heat. Those mostly used have been agaricine mixture: agaricine, gr. i; trinitrine,  $\frac{m}{g}$  xx.; spts. vinii gallici, f3 iv. Brandy, digitalis, gloinoine, atropia, strychnine, elixir valerinate of ammonia and whiskey, of each  $\frac{1}{2}$  ounce per rectum, faradism, oxygen gas, infusion. The best results have been obtained from atropia,  $\frac{1}{100}$ , strychnine,  $\frac{1}{50}$ ; if these failed, infusion was resorted to. The reasons for my preference for atropia and strychnine are, the rapidity of their action and their stimulating effect upon the respiratory and circulatory centres. Atropia in moderate doses acts as a stimulant to the vaso-motor centres by accelerating the heart's action and contracting the arteries, with a general quieting effect on the cerebro-spinal system. Upon the respiratory centres it is a persistent stimulant. Its three great actions: 1. Sedative action upon the peripheral nerves; 2. Stimulating action on the respiratory centres; 3. Its influence upon the heart and vaso-motor centres. If too frequently repeated or given in too large doses, it causes vaso-motor spasm, followed by a dilatation of the vessels, and a great fall of arterial pressure. Strychnine is also a stimulant to the motor, vaso-motor and respiratory centres. In large and too often repeated doses, like atropia, it paralyzes those centres. Infusion was necessary in a number of cases, with but two unsuccessful results, the following two cases being the most important:

Female, æt. 18. Heart and lungs normal; urine, trace of albumin; temperature, 98°; Pulse, 136. Disarticulating at the hip-joint for sarcoma of knee. Operated by Dr. Van Lennep. Time of operation one hour and six minutes. Amount of ether used  $5\frac{1}{4}$  ounces. After operation, temperature 97°; pulse not traceable; respirations shallow. Infused one and a half pints of

salt solution. Twenty minutes following this, temperature 99°; pulse easily felt; respiration better. One hour later, temperature 100°; pulse 168; respiration 40. One hour later, temperature 103°; pulse 168 full, the reaction being excessive. Twelve drops of aconite tincture in four ounces of water, one drachm every one-half hour for six doses was given, followed by twelve drops of veratrum viride tincture in four ounces of water, one drachm every hour. In two hours temperature 102°; pulse 140; respiration 32. Stimulating nourishment, brandy and milk. Full recovery.

CASE II.—Female, æt. 39. Lungs, heart and urine normal. Temperature 100°; pulse 140. Carcinoma of cervix. Operated by Dr. Betts. Had haemorrhages for weeks; anaemic. Length of operation thirty-eight minutes. Amount of ether used, two ounces. During operation respirations and pulse became weak. Atropia  $\frac{1}{100}$ , strychnine  $\frac{1}{80}$ , and agaricine mixture administered. After operation, temperature 96°; pulse not countable; delirious. Infused two quarts and one pint. Eight minutes afterwards, pulse 164; color to face and lips. One hour later, temperature 99°; pulse 160; respiration 38. Full recovery.

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## THE AETIOLOGY OF CHOREA.

BY F. M. LAWRENCE, M.D., PHILADELPHIA.

(Read before the Trousseau Clinical Club.)

By the term chorea we of to-day understand a disorder far different from the hysterical dancing mania of the Middle Ages which found its cure in a visit to the shrine of St. Vitus. As defined by Dr. Bartlett, chorea is "a disease occurring mostly in children and young people, characterized by irregular involuntary movements of the voluntary muscles, said movements occurring both during rest and attempts at motion, interfering with the accuracy of voluntary movements, and not infrequently attended by evidence of mental weakness."

But what of the underlying cause of this so-called "insanity of the muscles?" Volumes have been written on the subject, the data have been carefully sifted and resifted and all sorts of

statistics have been presented ; and yet, after all this, the true nature of chorea is still in doubt. There are many theories, however ; and my purpose in the preparation of this paper has been not to present any new hypotheses but rather to consider those which have met with the widest acceptation, and to weigh the evidence for or against each one.

First, we will review the data upon which any conclusion must be founded.

Chorea is essentially a disease of early childhood and youth—of the emotional period of life. Moreover, it is far more common in the emotional sex, in girls. Fright, or other mental or psychical disturbance, is by far the commonest exciting cause. In at least one-sixth of the cases, and probably many more, there is a direct neuropathic heredity. Finally, it is like neurasthenia and many of the more serious mental affections, more often than not accompanied by a varying degree of anaemia. Viewed in the light of these facts, how close is the similarity between neurasthenia, dependent upon mental and physical exhaustion, and chorea, dependent upon instability of motor control ; both, in other words, due to defective cellular nutrition and both relieved as we all know by measures calculated to improve that condition.

But there are other facts to be regarded. As in anaemia, cardiac murmurs in chorea, usually mitral systolic, are heard with striking frequency, probably in one-half of all cases. How are these to be explained ? Many authorities look upon them as purely functional manifestations, but not a few regard them as of inflammatory origin, due to endocarditis. An attempt to go a step farther back has led these observers to recognize a direct relation between rheumatism and chorea, and impressive statistics have been presented in support of the belief. While it is not for me to antagonize so widely accepted a belief, yet a review of thirty-five cases recently seen in the Hahnemann Hospital Dispensary, lends no support whatever to the theory. In only two of the thirty-five cases was a rheumatic history obtainable, a percentage little if any larger than might be found in almost any series of cases of any disease. Against the rheumatic theory stands the fact that although rheumatism occurs three times in boys to once in girls, two girls to one boy are affected by chorea. Moreover, the choeric heart murmur like

the anaemic often disappears on recovery, which would hardly be the case were it dependent upon an endocardial inflammation.

Of the many theories advanced we can give thought only to a few of the more important. Kirkes, supported by Hughlings, Jackson and others, believes chorea to be dependent upon minute emboli which are carried from vegetations upon the valves of the heart and become lodged in the capillaries in the corpora striata. Supporting this is the fact that such lesions have been found in a few fatal cases, and in lower animals an induced capillary embolism of the corpora striata has produced choreic movements.

A more recent theory is that of Professor Dana, who defines chorea as a disease "primarily of the bloodvessels and blood with secondary degeneration in the parenchymata, due to some microbe, or toxic substance, or both." "The anatomical seat varies, but it is chiefly in the cortical or sub-cortical motor centres." Although this can hardly be regarded as a satisfactory explanation, it is in line with the belief of Professor Koch in a microbic origin. Recent bacteriological researches by Pianese resulted, in three out of fifteen cases, in the isolation of a bacillus from the blood, inoculation with which caused the appearance of the disease in dogs. The infectious theory finds further support in Triboulet, who reports three cases of secondary infection by the staphylococcus in chorea, and who believes that in four-fifths of the cases infection could be traced as the causative factor.

No matter how interesting these theories may be, however, none seem to me as tenable as the functional theory of Sturges. Certainly there has been found no constant pathological change, although in all probability a functional change implies an altered nutrition of nerve elements. Moreover, no pathological lesion known as occurring in other diseases will produce a true chorea.

For a proper understanding of this functional theory, we will have to momentarily glance at the modern view as to the physiology of the cerebral cortex. A mental "concept," to use the term of the logicians, results from the association of the different cortical cells receiving the impression which constitutes it. The stimulation of any one of these smaller groups

calls into activity others, and upon this association of smaller groups into larger depends a train of thought.

Only one train of thought can occupy the mind at one time. In consequence, should any impression be so intense as to force itself upon our attention, our conscious selection of concepts is at once destroyed; in other words, the action of the sensory cells is rendered so violent as to break in upon the train of thought. In addition, such a disturbance lessens the inhibitory action of the sensory cells of the cortex upon the cortical motor centres. If mild in degree, this is shown by the fact that the motor cells *per se* being incapable of originating movement, the individual stands motionless as a statue. But let the emotion be more severe, and the lack of control exercised by the sensory cells permits an increased inhibition by the cortical motor cells over those of the spinal cord, diminishing the normal rhythmical discharges by which the latter keep up the tone of the body, and so permitting general muscular relaxation to ensue.

Finally, let the stimulation be yet more severe and the control of the sensory cortical cells may be entirely lost. As a result, the motor cells rapidly discharge themselves, producing first convulsions, then exhaustion. This increase and subsequent weakening of the inhibitory influence of the cerebral cortex is manifested by other disturbances. Heart-beat and respiration are at first retarded, then become rapid and violent; digestion is arrested; there is an increased excretion of urine; the vaso-motor system is profoundly affected.

Such a disturbance of the nerve centres may result in degenerative changes, and thus we have neurasthenia, epilepsy, hysteria, chorea, the character of the disease depending upon the degree of development of the nervous system, its hereditary or acquired weakness and the duration and intensity of the cause.

True chorea is a disease of childhood and adolescence, the period when the cerebral cells have not yet developed that co-ordinating dominion upon which our "self-control" depends. The normal irritability of the nerve cells, always greater in female than male, has not yet diminished with age. Hence it is that violent cell action is readily excited by emotions, and the lack of habitual inhibition loosens the already irritable lower

centres. The normal muscular movements produced by emotion resemble most strikingly those of chorea.

In proof of the fact that chorea is a disease of cerebral origin, it is necessary only to note: 1. The movements cease during sleep. If the disease were of spinal origin, they would instead be exaggerated in consequence of the lessened cerebral inhibition. 2. The disease is unilateral. Spinal disorders are generally bilateral. 3. The arm is involved far more than the leg, because it is more directly under cerebral control.

To sum up, then, chorea is best considered a disease of the cerebral cortex, especially its superficial layers, and its manifestations are due to the lessened inhibitory influence of the superficial sensory cells over the deeper motor centres. As long as the motor centres are not damaged, the movements will take the form of involuntary movements, from the normally associated cells stimulating similarly associated muscles. When, however, the motor cells are involved in the lesion, and the uneven amount of involvement breaks up the normal associations, then will occur irregular contractions of muscles or portions of muscles.

This, I repeat, seems at present the most tenable of the hypotheses as to the nature of chorea. Further research may modify our views, but I venture to predict that whatever may be the explanation ultimately reached, its foundation will be the theory of cortical nerve instability.

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A NEW SIGN OF HEREDITARY SYPHILIS.—Dr. M. Krisowski, of Berlin, calls attention to the presence of radiating and linear cicatrices around the mouth as characteristic of hereditary syphilis, for they are due to syphilitic lesions of early life. Differentially, similar cicatrices might be dependent upon either lupus, cancroid or noma. But the scars of lupus are in plaques, irregular, less prominent and at the margins nodules are still to be found. Besides, lupus is not noticed in the first years of life. The youthful age would also exclude cancroid whose cicatrices are deep-seated, radiating and running towards a central and common point. The scars of former gummatae are patchy, radiating and also running to a centre. Noma yields a scar that involves the whole thickness of the cheek and disfigures the face. Certain cases of so-called scrofulous eczema may greatly resemble hereditary syphilis, and, indeed, this form of syphilis may be treated for years as a scrofulous eczema until the destructive late effects break out. But this form of eczema, on healing, leaves no cicatrices, however thick the crusts be, for it is a disease of the epidermis.—*Berliner Klinische Wochenschrift*, No. 41, 1895. [The English, French and American writers have known these marks to be characteristic of hereditary syphilis for some time. Fournier, in his lectures on "Syphilis Hereditaria Tarda," describes them quite extensively. Hyde, *Journal of Genito-Urinary and Cutaneous Diseases*, No. 3, 1893, also mentions them, and thinks that they are never to be observed in non-syphilitics.—Ede.]

## EDITORIAL.

### CONSERVATION OF ENERGY IN THE TREATMENT OF DISEASE.

PERHAPS in no part of their practice are physicians found to differ so much as in the recommendations given their patients in regard to exercise and rest, and in none have they a more clearly defined and well-founded principle to guide them than in this, were it properly understood. In the doctrine of the correlation of forces, and of the conservation of energy we have principles, which, if thoroughly comprehended and rightly applied, will in all cases determine the manner in which we can most advantageously employ these two most valuable adjuvants, exercise and rest, in the treatment of disease. When to prescribe exercise and when rest, and how much of each, are questions upon the correct answers to which often depends the success or failure of our treatment.

We hear reference made to nervous force, muscular force, glandular activity, physiological processes, emotional disturbances, etc., as if they were separate and distinct entities, independent of each other, and related only by being activities of the same organism. Naturally we find, therefore, advice directed to measures for the reduction or increase of one or the other, without regard being had to the inevitable influence upon the remaining ones. Until quite recently we have been accustomed to hear plenty of out-door exercise advised for the tuberculous patient, regardless of the great waste of energy already taking place by reason of the morbid process going on, for the supplying of which the nourishment capable of being taken is insufficient. We hear muscular rest prescribed while the nervous wear and tear is only thereby increased. Again, we find forms of exercise prescribed indiscriminately, which not only use up the legitimate amount of muscular energy, but which demand also an extra amount of nervous force, thereby increasing the waste beyond reason. The compulsory inactivity of a business man, whose tangled affairs imperatively demand his personal supervision, and the prescription of horseback riding or bicycle riding for timid patients are every-day instances of such ill-advised instruction.

We will be guarded against mistakes if we remember that

there is a certain definite individual amount of energy inherent in each organism, capable of being increased by the economical use, or of being wasted by the extravagant outlay of the potential energy supplied it by the food taken and assimilated. No new energy can be created; it can only be appropriated from without. It is true that the power of appropriating may be developed, and therewith the store of energy be increased, but only as in purely material matters, by keeping the outlay below the income. The energy of which the various forces and activities of the human organism are only different manifestations, is the nervous energy. This it is which, through its various modes of connection, is transformed into muscular force, glandular activity, and these finally into heat, and this it is which is capable of retransforming and appropriating the energy stored up in the food taken. All measures, both hygienic and medicinal, depend for their success ultimately upon their restorative effect upon a perverted or exhausted nervous system. Were this not the case the beneficial effects of massage in the famous "rest cure" of Dr. S. Weir Mitchell for nervous diseases, would be inexplicable. The massage and electricity there applied are directly opposed to the idea of rest, but the distinctive feature is that the motion communicated to the muscles comes from without, and is not attended by the usual expenditure of nervous energy on the part of the patient.

In this connection we will allow ourselves a criticism of Dr. Mitchell's treatment of his "fat anaemic cases" by the "sole use of skimmed milk, cold or warm" in such an amount "as will thin the woman at a rate that will cost her about half a pound daily." We cannot but think, from our present point of view, that he is here violating both physiological and therapeutic principles, and that to this is owing the fact that he must refer to such cases "as the most difficult to manage of all curable anemias," and must say "that with the plan described he has been *almost* (the italics are ours) as successful as he could desire." Further, in one of the cases reported as successfully treated he speaks of the weight returning slowly, while in others the increase is usually described as being rapid. He acknowledges that "if she were afoot, this falling off would be severely felt, but when abed it is amazing how little annoyance it causes." A condition, no matter how produced, the effects

of which are only masked by artificial circumstances, can hardly be regarded as desirable. By restricting diet to limited quantities of skimmed milk he induces a condition of semi-starvation, wherein the katabolism exceeds the anabolism, clearly indicated by the debility which invariably attends this treatment. He wishes evidently to get rid of fat, which he cautiously admits may be what is popularly regarded as unhealthy fat, but while doing this he deprives the system of an amount of potential energy, the lack of which will sufficiently explain the debility and the slowness of healthy reactive metabolism, in spite of the "full treatment" which follows. Physiological experiments have proved that rapid metabolism is produced by the ingestion of proteids, but that a diet entirely free of fat and the carbohydrates is not sufficient to preserve, the nutritive equilibrium. Skimmed milk furnishes proteids, it is true, but not in the quantity that such cases are capable of appropriating, and the absence of fat deprives the system of an amount of potential energy which they can ill afford to lose. An increase of proteids with, at the same time, a moderate amount of fat and sugar will, we are sure, materially shorten the time required for a cure, as being more in accordance with physiological laws. When the doctor says, "it is sometimes necessary to substitute beef soup for a day at a time, on account of the disgust which milk may occasion," he virtually acknowledges that nature's demands dare not be entirely disregarded. Therapeutically it does not seem rational to attack one of the results of perverted nutrition—as which such accumulation of fat must be regarded—by a course of pure depletion which has no tendency to correct such perversion, nor to store up energy for the nourishment of the nervous system.

All treatment should be directed to increasing the potential energy of the system, first, by furnishing it in the most assimilable form by a well regulated diet: secondly, by increasing the powers of assimilation by the use of our remedial agents; and thirdly, by preventing unnecessary or excessive expenditure. In seeking to accomplish this last object the question of quantity is particularly to be considered; quantity of exercise and rest; quantity of recreation; quantity of food and medicine; quantity of clothing, etc., always remembering that there are for each individual certain physiological limits, up to which

the normal equilibrium of metabolism is maintained, beyond which it is disturbed, to the detriment of the system. Energy may be wasted in seeking to assimilate an excess of foods as well as in striving to carry out the various functions on an insufficient quantity. Energy is wasted, too, in the efforts of the system to correct the effects of wrong drugs, or to overcome the consequences of too large doses. In short, an excessive demand made upon any of the physiological functions is attended by a waste of energy, which is sure eventually to bankrupt the system, if not checked, but, *Abusus non tollit usum.*

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#### THE MATERIA MEDICA CONFERENCE.

At the Newport meeting of the American Institute of Homœopathy a resolution was unanimously adopted "To select a large committee of those interested in the *materia medica*, including several of our homœopathic specialists, to provide for the consideration and discussion of questions pertaining to the construction of a scientific *materia medica*, and to call and arrange for a *materia medica* conference in connection with the next session of this Institute, the conference to continue one or more days (as may be found necessary), and to adjourn finally before the opening of the Institute session—the committee to report its papers and discussions to the Institute for its action." In line with this resolution the committee has arranged for the conference to meet in Detroit on Tuesday, June 16, 1896, at 3 P.M., and to hold three sessions, the first from 3 P.M. to 6 P.M., the second from 8 P.M. to 11 P.M., and the third on Wednesday, June 17th, from 10 A.M. to 1 P.M. They have prepared for presentation and discussion at these meetings the following topics:

1. Has the "Law of Similars" ever been unequivocally demonstrated by the deductions from general practice, and do we not require its more formal proof by inductive experimental research?
2. In what particulars has the proving of drugs deviated from the rules laid down by Hahnemann in the *Organon*, and in what particulars do Hahnemann's rules and directions for proving drugs differ from, or fall short of, those required by the methods and precautions of modern scientific research?
3. In the search for the simillimum, shall we indorse Section

8 of the *Organon*, which says that the totality of the symptoms must be the sole indication to direct us in the choice of a remedy?

The unsatisfactory state of the *materia medica* shows clearly the need of such a conference for a searching fundamental inquiry, and if carried out as here suggested, in the true spirit of scientific research, this conference will be fraught with the utmost good for the homœopathic profession; and if the final outcome shall be a reliable *materia medica*, arranged and made ready for practical use, the most difficult problem of the century of homœopathy will be solved.

We have *materia medicas* in plenty, such as they are—but who is to decide which is the wheat and which the tares? This is something which should be within the reach of each one to do for himself. The great difficulty confronting the student is to get at, in a practical way, the real essence of the *materia medica*—the origin or source of symptoms, their reliability, their significance, their confirmation, etc. The *materia medicas* of first importance are those of Hahnemann, Hering, Allen and the *Drug Pathogenesis*. The ideal *materia medica* must show the origin of symptoms, the number of provers who have experienced them, the size and repetition of the dose upon which each is based, the time of the symptom's appearance, continuance and cessation, and the preceding, concomitant, and sequent symptoms—a complete picture of the drug action. To this must be added the well-authenticated clinical symptoms, by whom observed, and the conditions attendant; these symptoms to be distinctly stated as such in contradistinction from symptoms obtained in healthy individuals by drug action. And the arrangement must be such that the busy practitioner can readily get at them.

Not one of the above-mentioned *materia medicas* comes within the scope of this ideal. Van Denburg promises that his forthcoming work will supply all of this ideal and more, but as it is not out it cannot be taken into consideration. Hahnemann's is not so arranged. Hering has given a value to each of his symptoms, such being dictated by his own observations and those of others which he accepted. His judgment is worthy of respect, but a *materia medica* should enable each individual to place his own estimate on the value and significance of the symptoms. Allen's is a vast storehouse of observed symptoms,

hopeless in its magnitude. He, of course, is responsible for the symptoms he has seen fit to admit to his work, as he unquestionably passed judgment upon them; their source, however, is not obtainable, practically, and if the work had to be done over, the act of elimination would probably be extensive.

The *Drug Pathogenesy* is full of condensation and omission. The weeding and condensing has, no doubt, been ably done, but it has been arbitrarily done, and cannot be accepted, and the arrangement is such as to make it a working impossibility. We sympathize with those who consider that our *materia medica* will have to be recast, and that the "materia medica of the future" is still to be produced, and we trust that the three fundamental topics to be discussed at the coming *materia medica* conference at Detroit, will lead up to its speedy preparation.

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#### THE INTERNATIONAL HOMŒOPATHIC CONGRESS, 1896.

THE preliminary announcement of the International Homœopathic Congress is at hand and will be found on our "News" pages. On the whole, after a careful reading, it is disappointing and will dampen any enthusiasm on the part of Americans. The first thing to be noticed in the circular is the fact that the modesty of the British Homœopathic Congresses of 1894 and 1895 has appointed Englishmen to every office. All of the appointments are excellent, all being men of pre-eminent ability, and all will fill their offices acceptably and creditably to themselves and those present at the Congress. Still it would have been the part of wisdom, if not of modesty, to have appointed one or two officers from circles outside of their own nationality. The time and place of meetings will be accepted without question.

Section 4 appears to be an admirable provision and is worthy of a fair trial. The fact that no papers will be read at the general meetings is unique from the American standpoint. The "accepted essays" will be printed and supplied to all who desire to take part in the debates on their subject-matter. They will be presented at the meetings singly or in groups, according to their contents—a brief *analysis* of each being given from the chair, and the points on which they treat will be

thrown open for discussion, after an *appointed* opener (or openers) shall have been heard."

The italics are ours. It is not stated who is to accept the essays, who is to make the analyses, or who is to appoint the "openers"—all important prerogatives, which we presume the modesty of the British Homœopathic Congresses has kindly determined to assume and relieve other nationalities of annoyance.

With five years to prepare a programme, the presentation of the order of business, as far as at present arranged (February, 1896), is not such as to suggest to any one that it will be worth while to go to London on account of the Congress. Those who expect to be in London or its vicinity during their summer vacation will find but little to detract from their sightseeing. The first day is to be devoted to the president's address and reports on the history of homœopathy during the last five years from most of the civilized countries of the world, excepting the United States, to be followed by a discussion on the condition and prospects of homœopathy at the present time, and the best means of furthering its cause. This is a very timely subject, and the report of Great Britain should be taken up first and dwelt upon at length. The next day is to be given to institutes of homœopathy and *materia medica*. Five essays are provided, three English and two French. The first and possibly the second essay, from the standpoint of a homœopathic congress, promises to be of some value. The third day's schedule is not encouraging; a vague reference is made to "an American essay on some point in clinical medicine as yet unnamed." A paper is promised on "Colchicum in Gout," and another on "Mercury and Iodine in Syphilis." The fourth day is to be served up with "Purulent Collections in the Thorax," and "American colleagues have undertaken to supply two more papers on the day's topics, in which they have worked so largely and so well," and—this is all—with the refreshing statement: "We have no further need" of individual papers. Some reference is then made to a later announcement by "an American Committee which is co-operating with us." It will be interesting to know who the American Committee is, by whom appointed, and what it is doing. Will the American Committee please put itself in evidence and relieve the tension? Time is short and spirit is lacking.

**ROENTGENS' "X" RAYS FOR PHOTOGRAPHING THE INVISIBLE.**

THE recent announcement by Roentgens, Professor of Physics at Würzburg University, of the discovery of a new form of light, which will penetrate wood and flesh, but not bone and metal, has been immediately turned to practical account, and promises to open up an entirely new resource in surgery. The development of the whole subject is in its incipiency, and little is definitely known of its possibilities, but the promise of the future is decidedly attractive. The method, at present, is to generate a spark, or light, in the passage of a strong current of induced electricity through a vacuum, such as is obtained by use of a Crookes' phosphorescent tube; this light possesses the property of penetrating bodies opaque to ordinary light, and is incapable of reflection or refraction. It is not known whether its waves are longitudinal or transverse. It has qualities of phosphorescence and fluorescence. It has been called the "X" rays, and Roentgen distinguishes these "X" rays as sharply from cathode rays as from ordinary light rays. The light passes readily through vulcanized fibre, ebonite, carbon, wood, cardboard, flesh, leather, slate, etc.; copper, aluminium, and iron, being also penetrated, but with considerable variation in degree, while glass obstructs its rays.

These newly discovered radiations, proceeding from the vacuum tube under the influence of the electric discharge, were at once applied to photography, and its practical use has already been demonstrated by displaying bone lesions, the presence of foreign bodies imbedded in tissues; and it is reported that Neusser, of Vienna, has obtained photographs showing gall-stones *in situ* and a calculus in the bladder. The human hand has been frequently photographed, showing distinctly the shape of the bones, with their joints, in the fingers. The phalanges and metacarpal bones are produced with distinctness of substance and outline, with almost clear gaps between the joint-ends of the bones, due to the transparency of cartilage to these rays. One specimen faithfully revealed the location of a piece of imbedded glass in a man's hand, another demonstrated with great clearness and precision the injuries caused by a revolver shot in a hand and the location of the bullet.

It is evident that as soon as the conditions of these experiments become perfected and simplified, the possible application of this remarkable discovery, and the results to be obtained, will be of ever increasing value and brilliancy.

## GLEANINGS.

### GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D., AND FRANK H. PRITCHARD, M.D.

**A FORM OF MYOCARDITIS OF ALCOHOLIC ORIGIN WITH CONSECUTIVE LESIONS OF THE LIVER AND INTERMITTENT ALBUMINURIA.**—Prof. Aufrecht claims to describe, for the first time, a form of myocarditis, with consecutive involvement of the liver and associated with intermittent albuminuria, all of alcoholic origin. This morbid entity forms a disease distinct by itself, both clinically and anatomicopathologically. Several details of the affection have been already presented by various observers, yet the different periods of the disease are so distant, one from another, that it is impossible to follow the patients, except in private practice. In hospitals it is usually confounded either with a valvular heart lesion or with a chronic nephritis. In the beginning there is an increase of the area of heart dulness and sometimes a slight systolic murmur. At a more advanced stage one will meet with ascites, anasarca, and either an increase or a decrease in size of the liver, with albuminuria. The state of these patients seems desperate unless one be familiar with the disease. At the necropsy one will be surprised to find the kidneys in the same condition or cirrhotic and the characteristic signs of myocarditis-dilatation of the heart's walls with thickening. The patient is usually a person of middle age who, after having used alcoholic beverages to excess, but in good general health, or even somewhat obese, notices that he is short of breath on speaking or on mounting stairs. The region of the heart seems painful to touch, and on examination a simple dilatation, with or without a murmur is found. Sometimes these dyspnoic seizures become more aggravated during walking and resemble those of chronic nephritis or of sclerosis of the coronary artery—angina pectoris. As a differential point it is well to remember that the attacks of dyspnoea in chronic nephritis appear as well during rest, while those of angina pectoris are accompanied by pain in the region of the heart.

Subsequently, hepatic symptoms made their appearance as complications. At first there is a simple tumefaction of the organ; but if it persists an interstitial hepatitis arises, which progresses to decided cirrhosis with its grave consequences. The kidneys are last attacked. Albuminuria is noticed, but it is intermittent as in chronic interstitial nephritis. The renal complications appear to be due rather to blood-stasis than to a parenchymatous affection, though it may finally terminate thus. Alcoholic myocarditis with its triad of cardiac, hepatic and renal symptoms does not present such an unfavorable prognosis as one would expect, provided that no permanent hepatic or renal alterations have occurred (as shown by the permanence of the albuminuria), and an appropriate treatment with abstention from the exciting cause is instituted. The morbid symptoms will disappear little by little, even if there has been considerable weakness of the heart, with irregularity of the pulse, ascites, anasarca and even uremic attacks. Cases of uremic coma of several days' duration may be followed by recovery.—*La Semaine Médicale*, No. 48, 1895.

**A CASE OF PNEUMONIA WITH A TEMPERATURE OF 113.9°.**—Dr. Stanley communicates the case of a woman of 30 years who entered the hospital with a pneumonia, in whose case the temperature one day arose from 102° to 113.9° in the course of three and a half hours. After two doses of antipyrine of one half a gramme (grs. vijss.), the temperature fell to 104°. Then there was neither restlessness nor delirium, but she had lost all sense of feeling in her hands and feet, and declared that very warm applications were cold. The two days following the temperature remained in the neighborhood of 101.5°, but the third day the fever again rapidly rose to 11.9°. She was so weak that antipyrine was not given, but she received instead a solution of the acetate of ammonia. The day after the temperature was normal, and she went on to recovery.—*Norsk Magazin for Lægevidenskaben*, No. 7, 1895.

**A RARE DISEASE OF THE TONGUE.**—Dr Jakowlew recently presented a patient before the Russian Dermatological Association whose tongue was covered with grayish and non-ulcerated infiltrated spots, which were more pronounced anteriorly than posteriorly or laterally, where they were rather linear. They also extended between the teeth, along the gums and the inner side of the cheek. No papules were to be seen on the palate nor cicatrices of ulcers. The iodide of potash had been administered without success. In 1879 he had had syphilis and had been treated specifically. No traces of the disease were to be found on his body. Prof. Tarnovsky regarded the disease as a very rare form of tuberculosis of the tongue, and referred to a similar case of his where tubercle bacilli had been detected.—*Vratch.*, No. 15, 1895.

**A CASE OF DOUBLE MITRAL LESION WITH AN ASSOCIATED MURMUR FROM FUNCTIONAL PULMONARY INSUFFICIENCY, AND ALMOST COMPLETE DISAPPEARANCE OF THE RIGHT RADIAL PULSE.**—Dr Gouget has recently observed in Prof. Jaccoud's wards, in Paris, a woman of 34 years, who presented a double mitral lesion, with a double presystolic and systolic murmur at the apex, associated with a sudden termination of the first sound of the heart. A low murmur was audible at the pulmonary arterial valve, which was prolonged and disappeared during the diastole. The aortic valve was normal. The necropsy revealed that the pulmonary murmur was functional from dilation of the valvular orifice. The aortic and tricuspid valves were normal. Another peculiar feature, clinically, was the nearly complete disappearance of the radial pulse. The greatest attention was necessary to detect the slightest signs of pulsation in either the radial, humeral, axillary or subclavian artery. On the left the pulse was easily felt; the carotid pulse on each side was perceptible but it was weaker on the right. The two external jugular veins presented a veritable venous pulse; if the blood were pressed out, they would refill from below. This latter series of phenomena was explained by the possible existence of an atheromatous plaque in the aorta which produced a stricture of the brachio-cephalic trunk but this was not found at the necropsy. Professor Popoff had reported a similar case where he explained the disappearance of the right radial pulse by the constant compression of the aorta and the origin of the brachiocephalic trunk by the gorged and distended vena cava and the innomata vein.—*La Semaine Médicale*, No. 49, 1895.

**PAROXYSMAL TACHYCARDIA.**—Dr. Lange states that at the examination of the patient it is often quite impossible to count the pulse-rate either in the radial, carotid or temporal arteries. Auscultation is rendered difficult and often it is impossible to differentiate the first from the second heart sound.

The first sound may be reduplicated from the contractions of the ventricles being asynchronous. Not all the pulse-waves reach the radial artery and the heart sounds assume a fetal character though more frequently they are clear and distinct; nevertheless, at times, a systolic murmur may be heard (slight). The hand placed upon the thorax does not perceive an impulse but only a series of diffuse vibrations. Percussion reveals an increase in the area of dulness especially of the left ventricle; this, however, is transitory and disappears with the attack. The urine passed during the paroxysm may be increased in specific gravity and contain an excess of urates but no albumin [a differentiating feature from the rapid heart of parenchymatous nephritis—Eds.]. The face of the patient is pale and the lips rarely cyanotic. Rarely are the veins of the neck and thorax distended and turgid or is there cough. When a paroxysm has persisted for several weeks the liver may augment in size and slight mucous râles may appear posteriorly, at the base of the lungs. In one case he was able to abort the attack by directing the patient to take deep inspirations, for fifteen to twenty seconds.—*Le Sperimentale*, No. 17, 1895.—[Belladonna 2x gave me good results in a case.—Eds.]

**PoISONING BY KOLA-CHOCOLATE.**—Dr. F. Schmey reports the case of a lady who after eating six chocolate drops that had been made with a preparation of chocolate containing kola, was seized, within an hour, with great weakness, headache, congestion to the head and vomiting.—*Weiner Medizinische Presse*, No. 42, 1895.

**HOW DOES CARDIAC WEAKNESS ARISE IN INFECTIOUS DISEASES?**—Dr. Romberg, of Leipsic, from experimental investigations, claims to have concluded that the cause of heart weakness and failure in infectious diseases to be due to both a paralysis of the vasomotor centre in the medulla oblongata and to an extra

amount of work being thrown upon the right ventricle. In case that the heart has been previously weak or diseased, it is often unable to sustain the increased pressure, and heart failure results.—*Deutsche Medizinische Wochenschrift*, No. 25, 1891.

**A CASE OF CHRONIC BELLADONNA POISONING.**—Dr. Mueller, of Munich, communicates an interesting case where a woman for about eleven months had administered to her husband in his coffee a decoction of belladonna root, whereby he, formerly a quiet, industrious and jovial miner, for a year had become so apathic that he felt incapacitated for any exertion. His sight decreased so that he could no longer distinguish money nor the finger nails on his hands. Everything went to his head; sunlight and warmth were intolerable, so that he demanded the window-blinds be continually closed. The smallest fragment of food would stick in his throat; noodles could no longer be eaten. He complained of torturing thirst and heat in his throat and drank eagerly. Violent attacks of delirium would set in at times, when he would make threats with a revolver, axe or a knife. At his work he picked on and attacked his fellow-workmen, which condition finally degenerated into a state of confusion associated with senseless acts. He was strikingly emaciated. He was first under treatment for a gastric catarrh. He then appeared pale, his cheeks were slightly reddened, and his pupils a little dilated. On being transferred to the hospital, in two days his vision became normal. He was good natured and with an enormous appetite and soon recovered his health. A child and servant girl who had accidentally drunk of his coffee fell sick and were saved with difficulty. An examination of the decoction revealed it to contain one and a half milligrammes of atropine to the teaspoonful. The patient had formerly suffered also from diarrhoea, alternating with constipation, as well as severe pain on urination.—*Medizinische Neuigkeiten*, No. 36, 1891.

**LUMBRICOSIS OF A TYPHOID FORM.**—Dr A. Chauffard reports the interesting case of a young Breton of eighteen years, a mason by occupation, who entered the hospital, April 25th, in a most miserable condition. His body was dirty; he was emaciated and weak; his face expressed suffering and apathy; his eyes were surrounded with bluish rings, and all his symptoms seemed to point to a serious abdominal affection, undergoing evolution.

The dryness of the nostrils and lips, which was almost fuliginous, the dulness of mind, the slight and diffuse headache, insomnia, gurgling in the right ileo-caecal region, with general sensitiveness of the abdomen and slight enlargement of the spleen, led one to think of typhoid fever; the more so, as he had been complaining for about eight days, and he had had epistaxis. But his tongue, which was broad, decidedly coated, and red only along the borders, and not trembling, was not that of a typhoid patient; his breath was fetid, and he was constipated; nothing abnormal could be detected either in the lungs, kidneys, or heart. Neither, at any time did he present the characteristic rose colored spots. The 2<sup>nd</sup> 2<sup>th</sup>, and 28<sup>th</sup> of April, his temperature oscillated between 102.5° in the evening and 100.5° in the morning, and the ileo-caecal gurgling disappeared; the sensitiveness of the abdomen localized itself to the pyloric region. On the 29<sup>th</sup>, seven and a half grains of calomel; epistaxis, and evacuation of one round worm (lumbricus); his temperature fell to 100°. On the 1<sup>st</sup> and 2<sup>nd</sup> of May, two worms were passed; temperature normal, except at two in the afternoon, when it rose to 101°. The next morning, one worm was vomited, when a diagnosis of lumbricosis was made. Anthelmintic treatment was then instituted—1 gramme (grains xv.) of chenopodium seeds. June 3<sup>rd</sup> and the next day, the same dose was repeated, and followed by 0.60 gramme (grains ix.) of calomel; result, eleven worms were passed the 5<sup>th</sup> and four the 6<sup>th</sup> of May. On the 7<sup>th</sup>, calomel was again given, and nine worms were expelled. On the 7<sup>th</sup>, 8<sup>th</sup>, and 9<sup>th</sup> the temperature, which had become normal, varied between 100.5° and 101.5, when it fell definitely. During all this time he suffered from epistaxis, at times for several days. After expulsion of the lumbricoides his general condition became better; his tongue cleaned up, his face lost its drawn expression, which he had retained until then. The chenopodium was continued in doses of fifteen grains a day, and he continued to evacuate from one to two worms every day or two until June 2<sup>nd</sup>; he having passed in all thirty-nine lumbrici from April 30<sup>th</sup> to June 2<sup>nd</sup>. From May 1<sup>st</sup> convalescence was definitely established; his appetite was good; he had gained over thirteen pounds from May 14<sup>th</sup> to June 24<sup>th</sup>.

This condition, though rare, may still be occasionally observed to-day. The

patient had undoubtedly drunk of dirty water, in that such a massive infection by the parasite was able to take place. The *gastro verminous* or *putrido verminous* fevers of the past century were very similar to the condition of this patient.

Typhoid fever could be excluded, as his tongue was not that of a typhoid subject; the fever was slight, and would fall immediately after a bath; his breath had an odor of fetidity which is not characteristic of typhoid, and no rose-spots could be detected. The aspect of his face was that thought by the old clinicians to be characteristic of *lumbricosis*. Therefore if round worms be present in large numbers, they are capable of producing a morbid state which will closely resemble typhoid fever. Methodical examination of the faeces for the ova of the parasite is requisite to ascertain if a definite cure has been accomplished. Care must be exercised in administering the remedy, chenopodium, as it may give rise to toxic symptoms.—*La Semaine Médicale*, No. 59, 189.

**ENLARGEMENT OF THE SPLEEN IN MASKED MALARIAL CACHEXIA.**—Dr. Gaillard described, before the Paris Hospital Society, the case of a young man of twenty-four years, a teamster by profession, who presented a voluminous enlargement of the spleen—25 cms. in length and 27 cms. in breadth. His liver was normal, his appearance cachetic; albumin was detected in his urine, but no signs of leucæmia were to be made out. He had never had intermittent fever, but, while a soldier at the age of twenty-one, in a malarial district, he had had the dysentery. The next day after being first observed, he had an attack of malarial fever of 102.5°, after which no rise of temperature was noted. Under the sulphate of quinine (0.0) and a maceration of cinchona bark, with a rigid milk-diet, improvement was rapid; the albuminuria disappeared: the spleen decreased in size over one-half in a month, and he resumed his occupation.—*Le Progrès Médical*, No. 23, 1891. [Bohn describes a form of dysentery due to malaria, which he claims is characterized by an absence of tenesmus, urging, and colicky pains.—*Jahrbuch F. Kinderheilkunde*, 1873, vi., S. 115. Professor Nil Filatoff (*Semiotik und Diagnostik der Kinderkrankheiten*, 2d ed., p. 112, Stuttgart, 1892) also directs attention to a periodic variety of diarrhoea which is of malarial origin. It usually attacks children of five to ten years. The patient has from three to five very offensive and fluid stools, usually following each other in rapid succession, while in the remainder of the day no passage, or a normal one, is observed. *This alternation of fluid and normal passages is characteristic.* The diarrhoea appears paroxysmally every day at about the same time, and principally in the night or the morning. The temperature remains normal; the patients have a healthy appearance, and after resisting various measures for months, the discharges will yield to a few doses of quinine.—Ebs.]

**LIVER DISEASES OF HEREDITARY SYPHILITIC ORIGIN IN SUCKLINGS.**—Dr. Hochsinger, of Vienna, has observed a number of cases in children, of which the majority recovered, where a certain degree of enlargement of the liver was to be detected. The surface of the organ was always smooth, and signs of hereditary syphilis were observable. Mercury brought about a retrocession of the symptoms, yet the hepatic enlargement was slow to disappear. A diagnosis was made from the coryza, florid exanthems, and in some cases osseous lesions were seen. Icterus and ascites were absent. The differentiation of rachitic enlargements of the bones from those of hereditary syphilis is difficult. An associated pseudo-leucæmic condition may be an accompaniment. Histologically, there is a diffuse chronic inflammation, with proliferation of the interstitial connective tissue.—*Muenchener Medicinische Wochenschrift*, No. 44, 1891. [Prof. Nil Filatoff, *Semiotik und Diagnostik der Kinderkrankheiten*, 2d ed., p. 142, states that in older children syphilis of the liver is characterized by enlargement of the organ, deposition of gummatous nodes and the formation of cicatricial contractions, which give the liver a lobular appearance. This disease may be diagnosed if the child has formerly suffered from symptoms of hereditary syphilis, as eruption, in the first year of life; later, ulcerative processes in the mouth and fauces and periostitis of the long bones; the mother will also have suffered, previous to the birth of the child, from frequent abortions. On palpation, the liver will be found enlarged and nodular. The diagnosis will be rendered more certain when under the use of specific treatment, for example, of the iodide of potash, the ascites decrease or disappear, the liver decreases in size and the general condition of the patient improves. The iodide of potash is undoubtedly homeopathic to gummatous formation.—Ebs.]

**MENTAL DISEASES OF OLD AGE.**—At the last meeting of French alienists and neurologists the discussion turned upon senile affections of the mind. Mania was held to show a greater inclination to raving and an irresistible impulse for movement; to sexual excitement even to satyriasis or nymphomania and quite frequent megalomaniac ideas as of being rich, etc. It most frequently ends in dementia but recovery has been observed. Melancholia is the typical mental disease of old age. In the simple form the depression is less pronounced and shows a great inclination to remit. Hypochondriac ideas complete absence of energy and weakening of volition characterize the clinical picture; sometimes this is interrupted by an act of violence to which the patient is driven by sudden cropping out ideas. Suicide is not infrequent but rarely is successful. A recovery is frequent. Melancholia with agitation is not always curable. Stuporous melancholy is very rare.

Hallucinatory confusion of mind is quite frequent in old subjects and probably is connected with atheromatosis of the arteries. It begins with symptoms from the circulatory and digestive apparatuses and mental irritability, inclination to tearfulness and poor memory. The acute stage with complete mental confusion, unconscious and violent movements; the patient jumps out of bed, tries to escape through the window or door, rolls upon the floor, runs with his head against the wall or strikes the door with it. The facial expression is dull and anxious. Feeding is difficult, the pulse is accelerated, small and irregular; the extremities and face are slightly cyanotic and sometimes there is fever. The pupils are unequal, there is hemiparesis and aphasia; syncope may set in. The prognosis is less favorable than in melancholia.

Senile paranoia is characterized by a rapid development of the disease and hallucinations of vision. In nearly all cases arterio-sclerosis is noticed. The frequency of erotic excitement is remarkable and the subject either feels youthful and is looking for a wife or he suffers from the meaningless jealousy of an old man with regard to his wife, who like him is old, impotent and weak.

Moral insanity also has been observed; therefore, the many cases of kleptomania, murder, and moral offences.

Senile psychoses are of great importance in medical jurisprudence, not only with regard to the offences mentioned but also to the question of the mental responsibility in making wills, in marrying or of deprivation of rights. Even after his death possibly in the will there are paragraphs which will decide as to the testator's mental health.—*Norsk Magazin for Lægevidenskaben*, No. 11, 1895.

## GYNAECOLOGY AND OBSTETRICS.

CONDUCTED BY  
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**THE TREATMENT OF RUPTURE OF THE UTERUS**—Fritsch.—1. As a general prophylaxis for rupture of the uterus in labor, with the head presenting in a narrow pelvis, the patient should be laid on the side towards which the head presses the bag of membranes. Forcing down with the pains is not allowable with the head above the brim. Labor can be hastened in Walcher's position (hips over the edge of the table and the legs hanging down) by carefully pressing the head down in the pelvis, with proper regard for the position of the uterus.

2. The patient should be delivered as soon as possible in threatened rupture of the uterus. That method will be selected which requires the least space in the canal. Perforation and extraction with the cranioclast offers the best chance for the mother in head presentations. In transverse presentations version should never be attempted except the child is living and very carefully in deep narcosis. Mutilating operations are always to be performed if the child is dead.

3. If the rupture is diagnosed and the child is in the abdominal cavity, laparotomy must be performed as quickly as possible for its removal. If the child lies partly in the uterus and partly in the abdominal cavity it must be extracted through the natural passages if the extraction can be easily accomplished. Laparotomy is to be performed under favorable external conditions for severe and persistent hemorrhage or if the extraction of the child is difficult.

4. Neither the tampon nor compression nor both will arrest the hemorrhage in

every case. Neither is ligation from the vagina a sure method, as the most blood does not come from the uterus but from the womb outside the uterus in the parametrium and in the abdominal cavity. The bleeding vessels can be ligated with certainty only by abdominal laparotomy. If the bleeding has ceased spontaneously for several hours and the pulse has improved, the patient should be treated with opium and absolute rest. The catheter must be used. No irrigation of the vagina or of the peritoneal cavity through the vagina is permissible.

5. The fact that the rupture lies mostly outside the body of the uterus shows that hysterectomy does not apply as a special therapeutic measure and is only to be performed if the interior of the uterus is apparently septic or if a myoma is present, in which case the operation is indicated.—*Centralblatt für Gynäkologie*, No. 25, 1895.

**THE MOST SIMPLE FORM OF TOTAL EXTIRPATION OF THE UTERUS**—Frank.—He showed a case before the gynaecological society at Cologne of complete procidentia of the uterus and appendages, which he had ligated with a rubber ligature three days previously, and then cut the uterus away with a few snips of the scissors. He claims for this method that the operation is absolutely without danger, the peritoneum is not opened, and that the rubber ligature is easily applied. If necessary, the bladder can be dissected from the anterior wall of the uterus and pushed up if the uterus cannot be drawn down. The stump can be made very thin by incising the vaginal wall before the ligature is applied. A large portion of the pelvic peritoneum is removed and shortened by this method.—*Centralblatt für Gynäkologie*, No. 42, 1895.

**THE OVARY AN IMPORTANT FACTOR IN THE ETIOLOGY OF ENDOMETRITIS**.—V. Swiecicki expressed the opinion that the influence of the ovary in causing endometritis was of great importance. He thought it might be well to divide cases into two classes, the ovigenetic and the infectious. Fungous endometritis belongs to the former class. Increased function of the ovaries from any cause produces congestion of the uterus. If this is continued long enough, the mucous membrane will become hyperplastic. The ordinary treatment of these cases is to curette the mucous membrane away; but the irritation causing the hyperplasia remains, and after a time the fungoid endometritis is again present. The influence of the ovaries on diseases of the genitalia is of extreme importance. The etiology of fibroid tumors is to be sought in the ovaries rather than in the uterus. Too little attention is given in therapeutics to general conditions; local treatment belongs rather to the infectious forms. Olshausen, of Berlin, confirmed the above statement. There is scarcely any doubt but that fungous endometritis is of ovarian origin. The same is true of exfoliative endometritis (membranous dysmenorrhœa). It is a matter of regret that interstitial fungous endometritis and glandular endometritis return soon after mere curetting if the cases are not treated afterward. Radical cure is obtained by thorough treatment afterward with caustics, so that the mucous membrane is destroyed (sterility).

Löhlein noted the importance of ovarian processes on the endometrium in juvenile glandular hyperplasia. The commencement of menstruation often has processes analogous to the climacteric. We find the same complaints of protracted menorrhagias.

Fehling and Veit are of the opinion that glandular endometritis is very rarely the cause of menstrual hemorrhage and dysmenorrhœa in young girls. It is far more frequently dependent on simple disturbances of nutrition of the blood-vessels on a chlorotic basis with slight stenosis of the os internum.—*Ibid.*

**GONORRHEAL ENDOMETRITIS**.—Gottschalk advises that in acute gonorrhœal endometritis no local treatment should be employed. He thinks that many cases of pyosalpinx can be traced to such treatment. He also warns against the treatment of gonorrhœa in the cervical canal during pregnancy.—*Ibid.*

**THE TREATMENT OF THE STUMP IN HYSTEROTOMY**—Hofmeier.—He now performs the operation by ligating the uterine arteries on each side and dividing them; he then passes a strong catgut or silk ligature deep down along the side of the uterus, so as to get below the lower branches of the uterine artery; the ligature is then tied. After the opposite side of the uterus is treated in the same way, the uterus can be removed without haemorrhage or a rubber ligature. If there is a bleeding point after amputation, the haemorrhage is arrested by a transverse ligature through the cervix. The cervical canal is thoroughly wiped out with a

sublimate gauze sponge, and is not cauterized, a proceeding which he strongly condemns, as it lowers the vitality of the tissues, and in this manner favors suppuration and interferes with the healing process. Peritoneal folds each the size of the top of the stump, have been previously dissected off, and are now laid, one on top of the other, over the stump, so as to give it a double covering and a double protection to the uterine cavity from infection from the stump. These folds are stitched down with fine catgut. He agrees with Zweifel that it is of paramount importance to interfere no more than is really necessary with the circulation in the stump, and to thus preserve its vitality and the life energy of the tissues. The primary disinfection of the vagina, cervix and uterus is also of very great importance. After the ordinary cleansing and disinfection of the vagina, he irrigates thoroughly the uterine cavity with a 20 per cent. alcoholic solution of carbolic acid, and irrigates the vagina at the same time. After the last injection the vagina is packed with iodoform gauze.—*Centralblatt für Gynäkologie*, No. 27, 1895.

## OPHTHALMOLOGY, OTOLGY AND LARYNGOLOGY.

CONDUCTED BY

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**STRABOTOMY.**—Landolt considers the advancement of the antagonistic muscle a much more valuable surgical procedure for the relief of squint than the tenotomy of the squinting muscle. Even of cases of simple insufficiency of convergence or divergence, where tenotomy is admissible, the results of the latter are often unsatisfactory, because a considerable portion of the adducting or abducting power is lost. When the squint is excessive, tenotomy is often inconvenient on other grounds. In the operation of advancement the excursions of the eye are always increased without any loss in the power of the antagonist. Moreover, both convergence and divergence gain more by this operation than by tenotomy. Finally, the operation of advancement never causes any disfigurement. Tenotomy may be considered in cases of motor insufficiency, latent squint, or squint of a low degree, according to most modern ophthalmologists; but Landolt believes that in all three classes of cases advancement offers greater advantages. It has never in his hands caused an over-correction of the defect. It must, however, be generally done on both eyes.—*New York Medical Journal*.

**ACUTE SUPPURATION OF THE MIDDLE EAR.**—In the treatment of acute inflammation of the middle ear a prominent place is usually assigned to iodoform and boracic acid. But while in many cases their use proved satisfactory, there are some persons who are highly susceptible to these remedies, and are unfavorably affected by them. Thus, Prof. S. S. Bishop, of Chicago (*Medical Standard*, December, '895) reports a case of operation for acute mastoiditis in which a dressing of boracic acid was the source of intense suffering, preventing sleep, while on substituting aristol this trouble at once ceased. That the boracic acid was directly responsible for the mischief was demonstrated by alternating between the two remedies, the application of aristol being always followed by instant relief. This experience led the author to the use of this drug in acute suppurative inflammation of the middle ear, and after an extensive trial and study of its effects in both private and hospital practice, he has come to depend upon it exclusively. He states that it is undoubtedly the best cicatrizing at our command, and appears to possess an anesthetic property to some degree. It does not block up passages and dam back discharges, is not easily dislodged or washed off the ulcerating surfaces. Its odor is faint and not offensive, and in the hundreds of cases in which Dr. Bishop has employed aristol he has never known it to irritate or produce pain. The best way in which to apply it is with the small pocket powder blower. This carries a current of the fine powder along passageways into minute cavities and leaves a complete coating on the surfaces without packing the parts. In cases where the discharge does not show a decided tendency to dry up rapidly, it is a good plan to first cover the surface with aristol, and then blow in a light covering over this with the boric acid, or it is sometimes preferable to resort to the latter alone or to alternate between the two—first the aristol treatment, then the acid. But when the part once stays dry, it is best to leave it alone entirely for about a week or even longer.

## MONTHLY RETROSPECT OF HOMEOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

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**THE THERAPEUTIC APPLICATION OF IGNATIA AMARA.**—After an analysis of the provings of *ignatia* upon the lines which he and his associates have made famous, Dr. Eldridge C. Price defines its therapeutic application as follows:

Clinical experience has long since demonstrated the fact that *ignatia* is one of the useful remedies in conditions resulting from depressing influences, such as grief, bad news, etc., but no two provers record sufficient action of the drug upon the mental sphere to give pathogenetic grounds for the use of *ignatia* under such circumstances. In fact, neurotic disturbances of all kinds are absent from this collection of symptoms. The nearest approach to conditions of this character may be found in the headache the eye-sensation and the abdominal cutting pains. We feel justified in calling attention to only the following therapeutic uses to which *ignatia* may be applied from a strictly demonstrable pathogenetic standpoint.

**Headache.**—This may be pressive or dull, no acute pain being noted, and the "nail" symptom is entirely absent. The frontal region is most prominently affected, which leads to the supposition that the drug should prove useful in headaches arising from disturbed digestion. Add to this vertigo, confusion or emptiness, and sometimes heaviness of head, and we may turn attention to the stomach as the cause of offence. Diminished appetite and nausea are also sometimes here present.

On the other hand, a frontal headache spreading to other parts of the head would cause us to suspect simple neuralgia. The eyes are also sometimes involved to the extent of a sensation of pressure in them; and another characteristic symptom is the feeling as if the right eyeball was being pushed out. Possibly this is due to congestion. We may, therefore, consider that *ignatia* should relieve either gastric, neuralgic, or congestive headache, when the symptoms of the sufferer bear a resemblance to those of the drug.

**Indigestion.**—In cases of gastric disturbance in which the appetite is diminished, eructations and nausea are present, with inclination to vomit—though this rarely occurs—painful pressure in the stomach, increased flow of saliva, unnatural taste in the mouth, together with dull pressive headache, *ignatia* should give relief.

**Colic** may be added to the distress; the pains being "cutting" and located in either the umbilical or hypogastric region. Painful sensations in the splenic region would lead to the supposition that accumulation of gas in the splenic flexure of the colon was the cause of the pain; though it is possible the spleen itself may be involved, and congestion be present.

**Diarrhea.**—Resulting from the foregoing intestinal disturbance, we find defecative action stimulated. The stools are liquid, and follow the cutting pains in the abdomen.—*Southern Journal of Homeopathy.*

**CANNABIS INDICA IN DELIRIUM TREMENS.**—Dr. Olivé, of Barcelona, recently observed a case of delirium tremens in a patient of 28 years who had been drinking for some time. He had had cold sweats followed by dry heat of the skin, with general perspiration; the nights were filled with troubled sleep and anxiety; he had a dry cough and pain in the hypochondria. The morning would come with a multitude of hallucinations and extravagant ideas: incoherent loquacity with intervals of silence during which he seemed singularly stupid, with stuttering speech and a tremor of the lips. His extremities and particularly the upper ones,

were in a continuous and irregular tremor. His eyes were brilliant and animated ; headache, but no other pain anywhere. His face was congested and swollen ; he suffered from constipation. His skin was covered continually with sweat ; his muscles presented uninterrupted twitching, his thirst was unquenchable, his pulse frequent, soft and weak, and an eternal agitation rendered him an object of pity. *The nervous tremor, delirium, with hallucination and extreme thirst* led to the prescription of cannabis indica "x. The following day an amelioration was noticeable. The delirium had ceased, the headache disappeared and the tremor had much diminished. His bowels had moved and he felt decidedly better. In five days he had wholly recovered.—*Revista Homœopatica*, No. 9, 1895.

**KALI BICHROMICUM IN LIVER DISEASE.**—Dr. Ide, of Stettin, Germany, has found this remedy to be of service in the following symptoms : Pain in the region of the liver posteriorly ; pains in the right hypochondrium and in the corresponding portion of the lumbar region, here resembling chel., which pain is better on eating, while with kali bichr. it is ameliorated after eating ; lumbar pain ; a metallic taste ; a stinking breath ; a tongue which is thick, broad and covered with a nap like coating ; there is distress from distension of the abdomen ; a clay-colored stool, watery diarrhœa and tenesmus ; the head is confused, the skin pale and yellow, the conjunctiva icteric, and the affection is worse from movement, breathing, coughing and after beer drinking.—*Zeitschrift des Berliner Vereines Homœopathischer Aerzte*, Bd. xiv., Hft. v., 1895.

**BISMUTHUM SUBNITRICUM IN PYROSIS.**—Dr. K. was consulted by a farmer at. 40, who had suffered for five years from acid eructations of fluids from the stomach. The pyrosis was fully as severe before as after meals. He had a good appetite, he digested his food well and otherwise was healthy except that the sour eructations distressed him greatly. He had already employed various allopathic remedies without success. Bismuth. subnitrate 4x was prescribed, five drops four times a day. In fourteen days he was much better. He received a second supply of the remedy, to be taken twice a day. In a short time his disease had disappeared.—*Homœopathisch Maandblad*, No. ii., 1895.

**A FEW REMEDIES FOR RHEUMATISM AND THEIR INDICATIONS.**—In the *Leipziger Populaere Zeitschrift fuer Homœopathie*, Nos. 21 and 22, 1895, the following remedies and their indications, in rheumatism, are given :

*Rhus Toxicodendron*.—Aggravation at night on becoming warm in bed ; in damp, cold weather, and on attempting to move about ; amelioration by continued motion and warmth. The disease affects, preferably, the articulations (?). Restlessness, and a continual desire to change one's position.

*Chusticum*.—Amelioration and even complete cessation of the pains on resting, or on becoming warm in bed, although the sleep is restless ; aggravation on moving about.

*Rhododendron*—"Barometer pains." A violent appearance of the pains before every storm ; aggravation from cold and during resting.

*Bryonia*.—Piercing pains. Amelioration of all the pains, excepting headache, during rest and on becoming warm. Aggravated by movement.

**ALLIUM CEPA' AND ECPhRASIA OFFCINALIS.**—Both are remedies that affect the membranes, and especially those of the upper air-passages and eyes, with the difference, that, in euphrasia the secretion from the eyes makes the lids sore, and that from the nose is of a mild and non-corrosive nature ; cepa is the very opposite ; the lachrymal discharge is bland and the nasal secretion irritating. Cepa is also the most important remedy in neuralgia following amputation of the stump. —*Ibidem*.

**KALI BICHROMICUM IN SKIN DISEASES.**—Dr. Ide, of Stettin, Germany, points out the influence of the remedy, kali bichr., upon the skin. Here we meet with all stages of inflammation, from hyperæmia to ulcerous destruction. We have erythema, papules, pustules, ulcers as with tart. emet. and croton tiglum. Therefore it has been employed with success in measles, where the patient is hoarse, complains of dryness of the throat, and of a sensation of a foreign body or of a plug in the throat ; also when there is coryza, a violent and dry cough with difficult expectoration of a tenacious, stringy, and even of a bloody mucus. If one recall its characteristic ear and eye symptoms, one will see its close homœopathy.—*Zeitschrift des Berliner Vereines Homœopathischer Aerzte*, Bd. xiv., Hft. v., 1895.

**RUTA GRAVEOLENS IN WEAKNESS OF THE EYES AFTER THEIR OVER-USE—**  
Ruta graveolens is praised as a remedy, both locally and internally, in weakness of the eyes from their over-use. This condition will be especially observed in seamstresses. The fourth dilution has been found most serviceable. Externally, an infusion of the leaves may be employed.—*Homœopathische Monatsblätter*, No. ii, 1895.

**THE URIC ACID DIATHESIS IN CHILDREN.—**Dr. Donner, of Stuttgart, Germany, from a series of observations has come to the conclusion that the uric acid diathesis plays an important rôle in the diseases of children. Locally, in the urinary tract, one observes renal colic, which is often regarded as of abdominal origin; inflammations of the bladder and renal pelvis; the children must urinate frequently; their urine is turbid and causes pain both before and after urinating; sometimes, even with occasional clear urine, the micturition is irregular and painful; they wet the bed at night, cry out in sleep, and the region of the kidneys is often very sensitive to pressure. At times, blood and albumin may be observed in the urine, and the patients were regarded as having diseased kidneys; on microscopic examination, neither casts nor renal epithelium were to be found; therefore a diagnosis of renal disease had to be excluded. On the contrary, a considerable quantity of uric acid was discovered, and the remark made, that with the increase or decrease of this substance the albumin would also keep pace, and after relief of the acid condition the albumin would disappear.

As to general symptoms, there are headache, restless sleep, dyspepsia, constipation, indefinite pains of a neuralgic character; one day they complain of one pain, and the following day of another. There may be palpitation of the heart, irregular pulse, anæmia, an inclination to nose-bleed, to urticaria and itching eruptions, etc. At times, only certain symptoms would appear in the foreground; at others, a whole complex; in one case the general symptoms would be noticed in connection with the local ones; or the former only be present when the local signs would not be noticed for some time. A quite definite diathesis is noticeable in many cases. The child is delicate, restless, with precocious mental development; nervously excitable; at one time very vivacious, at another depressed, as Goethe strikingly and inimitably describes it, "bald himmelhoch jauchzend, bald zu Tode betruelt." Its sleep is restless and interrupted by dreams; it falls asleep with difficulty and awakens early; its appetite is bad and capricious; the feet are inclined to be cold; tonsillitis easily complicates; pharyngitis, croupy cough, constipation and headache appear frequently; in short, they are neurasthenic. These symptoms may persist for years without injuring the organism; in other cases, symptoms of grave disturbances of nutrition set in which threaten life and eventually prepare the soil for tuberculosis or other infectious diseases. Diabetes, rachitis, obesity, scrofulosis, etc., may be brought about by the disease. A stone in the bladder or kidney may be the result. Neurasthenia or contracted kidney may be the final outcome. The children of gouty and rheumatic persons are especially liable to the disease. It may be acquired by living in damp, unhealthy houses in a swampy region; and from improper food, where too-long continued meat-diet plays an important part. A sudden breaking off from meat to change to a vegetable diet is not advisable. Fruits, and especially strawberries, raspberries, grapes, etc., together with hydropathic measures, lukewarm baths, packs, or steam baths, are of service.

Homœopathically, the chief remedies are: Natrum sulph. and natrum mur., best given in alternation; then coccus cacti, tart. borax, urtica urens, in tincture; lithium carb., natr. citr., and arsen.—*Homœopathische Monatsblätter*, No. ii, 1895.

**AGARICUS IN THE TREATMENT OF CHOREA.—**Dr. Henry Chandlee reports a series of eight cases of chorea in which *agaricus* was prescribed on its well-known indications, all of which were much improved by the use of the remedy.—*Southern Journal of Homœopathy*, November, 1895.

**THE ORIGIN AND ACTION OF NEURINE, MUSCARINE, AND CHOLINE.—**In the course of an article upon "The Errors of Digestion" Mr. C. R. Niven says:

"Brieger, by sowing bacteria on flesh, obtained a very poisonous alkaloid which he called 'neurine,' and in the same way from fish he obtained 'muscarine.' Other bodies were got, but at present we may neglect them. The great value of Brieger's experiments lies in the fact that he crystallized these bodies and subjected them to chemical analysis, and was not content with getting simply ex-

tracts. This second body, muscarine, is of interest to us as homœopathists because it is identical, or nearly identical, with our old friend 'agaricus muscarius,' and had never before been obtained except from the vegetable source. Now suppose either flesh or fish is eaten just before it can be said to be tainted, the high temperature of the body will cause the putrefactive act that was just beginning to progress rapidly, and thus a great amount of these alkaloids may be produced. This fact is of the greatest importance, because a person, or a number of persons, may be attacked with gastro-intestinal disturbance set up by these poisonous products, although the part uneaten may still seem sweet. It is, perhaps, with milk that we may oftenest have to do in cases of this kind. How many children do we see in summer with violent vomiting and diarrhoea although the mother may tell us that the milk the child got was quite sweet and the bottle quite clean; indeed, if the milk be examined it may still seem sweet, though the examination be some hours afterwards. It may be the milk was 'just on the turn' and although it may remain sweet for some hours longer, yet in the child's stomach a very poisonous product may be produced, the putrefactive action being accelerated by the bodily temperature. Our other, and third example, another very important alkaloid, named choline (because first obtained from bile), is got by boiling bile, or yolk of egg with baryta. Now choline and neurine are closely allied chemically, and choline if oxidized by strong nitric acid gives artificial muscarine.

"Muscarine is much stronger than choline, and has a marked action on the heart of a frog, which choline has not; artificial muscarine is still stronger, and has a paralyzing action on the ends of motor nerves like *curea*, which natural muscarine does not seem to have, or only very weakly. The action of these three bodies—neurine, muscarine, and choline—is the same. They all produce salivation, diarrhoea, vomiting, dyspnoea, paralysis and death. Though they all do this, it is not in equal degree, for the power of neurine is ten, and of artificial muscarine, fifty times greater, than that of choline. They stimulate the glandular organs, because with salivation there is secretion of tears and moist râles in the chest. The dyspnoea is probably due to a stimulation of the medulla, or possibly to contraction of the pulmonary bloodvessels."—*Journal of the British Hom. Society*.

**CONIUM FOR PAINFUL STIFFNESS OF THE FINGERS.**—Dr. Wingfield records the case of a Miss X., at. 25, employed in an insurance office, who for six months had suffered from loss of power of the right forefinger and middle finger with stiffness, numbness and excruciating pain. She was healthy in every other respect. The pain prevented her writing, but it did not seem to have been produced by this, for she had not used her pen to excess. Many remedies were tried without success. The only treatment that relieved was the faradic current, which at once removed the pain and stiffness, but it returned again in two or three days after each application as bad as ever. Finally, the battery was stopped, and *coniunum 1x*, gtt. ij., every three hours, ordered. In two days the stiffness, numbness and pain were removed, and three weeks after there had been no return; the fingers remained well.—*Monthly Hom. Review*.

**PLUMBUM IN CHRONIC CONSTIPATION.**—Dr. Wingfield records these two cases:

**CASE I.**—Mrs. D., at. 50, married, no children, for fifteen years has suffered from constant constipation. Has tried many remedies without effect, and now has to take a teaspoonful of cascara sagrada extract every other night to get an evacuation. She is a sparely built woman, very nervous; her tongue is coated with a whitish-yellow fur; she complains of constant headaches, and after each motion she is thoroughly exhausted and has to lie down for the rest of the day; bowels never act without cascara, and then only once. Ordered *plumbum metallicum 6x*, one three-grain tablet to be taken twice daily. Two days after commencing treatment, the bowels acted naturally, and have now done so every day for the last three weeks. Her headaches are gone, tongue is clean and she is much less nervous.

**CASE II.**—Miss M., at. 25, florid complexion. She complains of boils appearing on face and arms and chronic constipation. The latter has been a trouble since she was twelve years old. There is slight spinal curvature. Her general health is good, but tongue furred, and occasionally she has headaches. She suffers a good deal at the periods. She says she has been to "all the best physicians," and none of them gave her relief except by purgatives. *Plumbum metallicum 6x* was prescribed twice daily. This at once relieved the constipation, and

soon the boils disappeared. Her bowels for some time have moved regularly and she now feels quite well.—*Monthly Hom. Review.*

**RUMEX CRISPUS IN CHRONIC MORNING DIARRHEA.**—Dr. Wingfield reports the case of the widow of an old-school practitioner, at 60, who for ten years had suffered from morning diarrhoea. The motions were five or six in number, beginning daily about 6 A.M. and lasting till noon. The motions were liquid and watery. They made her feel very weak, and she had lately lost flesh and strength. She had been constantly under treatment during the whole ten years, but with so little effect that latterly she had given it up in despair, until induced to try homœopathy.

*Merc. cor.* was first prescribed, with some relief, but it was transient, and as after two weeks she was about the same, this was changed to *rumex crispus* 3x. An immediate cure was effected by this drug alone. In a few days the diarrhoea ceased, the motions gradually becoming formed and healthy. She remained under observation for a year, and had only one slight relapse from indiscreet dieting.—*Monthly Hom. Review.*

**AMMONIC-NAPHTHALINE NITRATE.**—A correspondent signing himself "Argicola," contributes to the *Homœopathic World*, the record of the case of an artisan, aged 40, who for many years had complained of an intense pain in the epigastric region, extending through to the back. Those medicines whose sphere is chiefly that of disordered digestion improved his general condition, and *nux vomica* benefited his constipation and hernia, but the old trouble continued almost unaffected. At this juncture the eye of the correspondent chanced to rest upon a phial of *ammonite*, an explosive manufactured in England, from which he himself had gained relief for a dyspepsia of life-long standing. Ten grains of the powder were given to the patient, with directions to dissolve one-half in a teacupful of water, and to take a teaspoonful four or five times daily. A few doses removed the pain, never, it is hoped, to return.

**IN WHAT KIND OF CHLOROSIS IS IRON INDICATED?**—Dr. Marc Jousset, of Paris, in discussing the remarks of Prof. Hayem on the recent discussion at the meeting of German physicians and naturalists with regard to the treatment of chlorosis, states that that variety of the disease, with amenorrhœa or diminution of the menses is the true sphere of ferrum. Not all cases of chlorosis will yield to iron, and the menorrhagic variety will be actually aggravated. The characteristic symptoms are: An earthy color of the face, with bluish spots or it is merely very pale; at the least effort or emotion the cheeks flush up suddenly, and immediately become pale again. There is a bitterish, bitter, or earthy taste in the patient's mouth. Emaciation, accompanied by swelling of the face and œdema of the extremities, with a dull pallidity of the tissues. The menses are intermittent; ammenorrhœa (this symptom is given by Hahnemann as a result of drinking ferruginous waters). On the contrary, the periods have also been noticed to have been profuse. Palpitation, anxiety, and dyspnoea. The principal symptoms are, however, diminution or disappearance of the menses.

What is the proper preparation and dose? While the German (allopathic and homœopathic) physicians speak highly of the carbonate, Hayem prefers the protoxalate. Jousset, on the contrary, would use the insoluble preparations, and he usually administers ferrum metallicum in the first decimal trituration, or even a trituration of equal parts of crude iron and sugar of milk; in cases where the periods are entirely suppressed the higher attenuations give better results as, for example, the sixth decimal.—*L'Art Médical*, No. 6, 1893.—[As Hayem states in another page of the *HAHNEMANNIAN MONTHLY*, the gastric affection which he claims is an associated condition and the cause of the chlorosis deserves first to be treated, and especially dietetically, administering those foods which have been demonstrated to contain a large percentage of iron in organic forms such as milk, raw meat, lean fish, green vegetables, etc. Dr Puhlmann *Handbuch der Homœopathischen Praxis*, p. 507, also calls attention to the importance of this detail in the treatment, for he says that if ferrum does not ameliorate then other remedies will do better. He advises ferrum carbonicum 1 to 2x where there is an inclination to sour stomach, sour eructations or ferrum citriolum 2x, with *nux vomica* 4x, in alternation, with the same indications. If there be only eructations of tasteless gas then ferrum sulphuricum 2x or ferrum haematiticum 2x is better given. In case that the stomach be unaffected the iron preparations are best given from the first; it is

judicious to continue the remedy for several weeks after the disappearance of the disease. Cases that have been treated in vain with ferram, often improve under the use of cuprum aceticum 3 to 4x, or arsenicum alb. 5x, especially where the patient is emaciated, has a craving for sour things and the stomach pains continually. Girls with an inclination to obesity and flabbiness of flesh should receive calcarea phosphorica 3x. I have found pulsatilla to be a useful remedy to precede the iron preparations; it will act well in the mentioned gastric catarrh. —Eds.]

**THERAPEUTIC SPHERE OF CYCLAMEN EUROPEUM.**—Dr Mossa calls attention to this plant which was snatched from oblivion by Hahnemann, and which deserves more notice than is usually given to it by homœopaths. It is an energetically acting remedy, and one endowed with decided toxic powers, which are due to a crystalline alkaloid, cyclamin.

In hemicrania it is serviceable, especially in women with vertigo, stupidity and cerebral congestion. The pain is said to be dull and pressive, sometimes tearing, gnawing, boring, but never violent stitching or shooting. It may persist for days or weeks continuously; it is never associated with nausea or vomiting; the pulse is not increased, nor is the temperature of the part but slightly elevated; appetite and thirst decreased. The patient lies on the unaffected side, for lying on the aching side or bending over increases the pain. No photophobia nor lachrymation, but the pupils are dilated, the eyes glittering and the look is stupid; objects are seen larger than they really are, and sometimes indistinctly; at times the lids are spasmodically contracted. In females, the menses are irregular and late. The drug has also been found of service in chronic nasal catarrh, with profuse secretion, with taste and smell diminished.

The remedy also has a decided action upon the eye, its muscles and nerves, for it has cured several cases of strabismus, diplopia and incipient amaurosis.

The lower extremities are so affected that a pronounced picture of tabes dorsalis is produced, though it has never been used clinically here. It greatly resembles pulsatilla in its action upon the female sexual organs. Farrington calls attention to its value in this class of affections. The female, a girl or woman, is chlorotic or anæmic, with a weak stomach, disturbed digestion and distress, or even aversion to fatty foods. The colicky pains and irregularities of menstruation are almost the same as those of pulsatilla. In both there is a melancholic tendency of the mind. But the pulsatilla patient feels better in the cool and open air, while with cyclamen the contrary holds good. The thirstlessness of pulsatilla is well known; with cyclamen it is less pronounced. Characteristic is a peculiar weakness, a sensation of exhaustion, clumsiness, a dulness of both body and mind, so that a stimulant from others is necessary to exert one's self, either mentally or physically. The eyes are affected; the patient complains of spots before them, colored vision or myopia. In a girl the period will be suppressed on account of excessive dancing; in another from getting wet; in both, cyclamen will set everything aright. An unmarried lady of thirty-five, after taking cyclamen, complained of a sensation of air pouring out through her breasts; these swelled, became painful and secreted a thin and milky fluid.—*Leipziger Populare Zeitschrift für Homœopathie*, Nos. 15, 16, 18, 19, 25. [Heinigke recommends the remedy in bilious typhoid, with colicky pains in the right iliac fossa, with constipation; also in uterus of hæmatogenous origin, for cyclamen has a decided action upon the red blood corpuscles.—*Handbuch der Homœopathischen Praxis*, Puhlmann.—Eds.]

**TREATMENT OF VARICOSE ULCERS.**—Dr. Lorbacher, of Leipsic, directs attention to the value of certain remedies in varicose ulcers.

*Arsenicum* is indicated in violent burning pains in the ulcer, which has a relaxed and dirty appearance, with hard and elevated margins, and excretes a thin and grayish ichor which may cause an erythema to extend over the whole leg, forming an oozing surface. The patient is cachectic, may live in an unhealthy dwelling and is poorly nourished.

*Rhus toxicodendron* is also held to be indicated with this series of symptoms, yet he has had but little success with it. On the contrary, *causticum* is a close competitor of arsenicum; it presents the burning pains, an acrid, grayish secretion, with an ulcer of elevated edges in old subjects especially.

*Sulphur* has an inclination to eruptions, together with the ulcer which is of itself but little painful. The discharge is more purulent and not corrosive.

*Silicea* presents an ulcer with a profuse secretion of pure pus; great painfulness where the ulcer is situated over thinly covered bone as in the lower portion of the leg.

*Lycopodium* in its provings shows stasis in the abdominal organs, and an inclination to varicose ulcers, and the remedy is especially of value in pregnant women.

*Carduus Marianus* has been praised by one German homœopath as a panacea for varicose ulcers. It is of use but the results have not been as good as he claims.

*Lachesis* has a characteristically bluish ulcer, with a spongy consistence and a dark and bloody discharge, especially where the cachectic appearance of the patient points to an ulcer from a profound general affection and a low state of the blood-preparing organs—*Allgemeine Homœopathische Zeitung*, Nos. 15-16, 1895.

Dr Moeser is an earnest advocate of the treatment of varicose ulcers by homœopathic remedies; he rejects all local antiseptic measures beyond a clean occlusive bandage. He begins the treatment of every case with sulphur after which one may follow with calcarea, silica, lycopodium or eventually lachesis, but from time to time, a dose of sulphur is intercalated. If he thinks a low potency to be indicated, then he employs above all, the lime preparations and indeed one of the three, calcarea sulphurica, calcarea fluorata or calcarea arsenicosa. All three act excellently. As to vegetable remedies, there are also three that act well, in these ulcers and low potencies; carduus marianus, hamamelis and phellandrium aquatum; the last two may also be employed externally, in a salve.

Wet applications are not always well borne; if a dry dressing be necessary then he dusts on either the first or second decimal trituration of carbo vegetabilis especially if the ulcer ooze and smell badly. Locally one may apply the leaves of *tus-silago farfara* or *plantago major*. Rest with the leg in the horizontal position is necessary; standing is especially to be forbidden—*Homœopathische Monatsblätter*, No. 10, 1895.

Dr. P. Jousset, of Paris, speaks very highly of *clematis vitalba* in the management of varicose ulcers. He employs from the third to the sixth decimal potency internally while locally he applies the first decimal trituration.—*L'Art Médical*, No. 6, 1895.

**JARACANDA IN SORE THROAT.**—Dr. J. F. Convers finds jaracanda to be a serviceable remedy in acute sore throat or pharyngeal catarrh when there is difficulty in swallowing, no tonsillitis, but the throat is hot and red, swallowing painful and a great number of small vesicles are noticeable in the throat. He employs the tincture both internally, two drops every two hours, and as a gargle. It has helped him out where acon., mercu., bella. and phytolacca have failed.—*Manned-schrift foer Homœopathi*, No. 7, 1895.

**CALCAREA CARBONICA AND SILICA IN TABES MESENTERICA.**—The distinguishing features of this disease with regard to the choice of a remedy, are the sweat, abdominal temperature, and the appetite. Calcarea is indicated, if the sweat of the head and abdomen are cold and the child always wants to nurse or to eat eggs, and especially if there is general hyperacidity or a greenish diarrhea. Silica, on the contrary, is to be given if the sweat is sour and fetid, the abdomen warm, and the child has an aversion to its mother's milk or to any warm and cooked food, and principally if there be constipation. In both remedies the little patient is obstinate, capricious, and fretful. The silica child is prone to scream out, even if one speaks gently to it, while the calcarea patient is easily frightened or is afraid of everything that it sees.—*Rivista Omnipatica*, Luglio Agosto, 1895.

**TREATMENT OF HERPES ZOSTER.**—Dr. Seutin advises against employing any local measures beyond dusting the vesicles with finely powdered starch, and then covering with a layer of sheet-cotton. The true homœopathic specific of herpes zoster is cantharis; and it is rare, he claims, that one will be obliged to have recourse to any other remedy, for this drug will give one decided results. In chronic cases, other remedies may be necessary, as arsenicum, causticum, rhus, petroleum, or mezereum.—*Journal Belge d'Homœopathie*, Juillet et Août, 1895.

**CYCLAMEN AND PULSATILLA.**—The striking resemblance of the two remedies in many ways is pronounced. Cyclamen is adapted to blonde and leucophlegmatic subjects, as pulsatilla also is, and for which it is regarded as the classic remedy. In both there is a decreased or suppressed menstruation, numerous gastric symptoms, aggravation from greasy or fatty foods, anaemia, coldness and chil-

lines, as well as the absence of thirst though this may be present in the evening.—*Rivista Omiopatica*, Luglio Agosto, 1895.

**THE ACTION OF KALI BICHROMICUM UPON THE KIDNEYS.**—Dr. Ide, in a paper read before the recent meeting of the Central Union of German Homœopaths on the action of kali bichromicum, states that one of the most important centres of action of this drug is upon the kidneys. Here it greatly resembles kali chloricum. A characteristic symptom which this remedy presents is, pain in the back upon micturating. Berberis and rheum have pain in the back on urinating, and graphites in the coccyx, a symptom that kali bichrom. has *after* micturition. In cases of uric acid diathesis, with gravel and renal sand in large quantities in the urine, he thinks it indicated. A woman of forty-five years suffered from this diathetic state, and who for three months had been subject to attacks of renal colic; after suddenly appearing pains in the left loin, there followed vomiting, continuous tenesmus vesicæ, stitching pains in the urethra, anuria and palpitation of the heart; after colocynthis had been given in vain, kali bichrom. 1:2 cured.

In a woman of 31 years who was suffering from a coxitis, probably of tuberculous character, there was also an associated dropsy, and the urine contained a slight sediment of a whitish appearance, which consisted of epithelia and mucus together with a high percentage of albumin. The renal affection was cured in three weeks by kali bichrom., while the hip disease remained unaltered.—*Zeitschrift des Berliner Vereines Homeopathischer Ärzte*, 1895.

**TREATMENT OF PRURITUS.**—Dr. J. P. Tessier considers the following remedies as chief in the treatment of this troublesome affection: Carbolic acid, salicylic acid, antipyrine, chloral, euphorbium, mezereum, naphthaline, opium, and especially morphine, rumex and vanilla.

*Carbolic Acid.*—Though this remedy has no homeopathic pathogenesis pointing to pruritus among its symptoms, Dr. Augagneur (allopathic) is very enthusiastic in its praises [of its local action, probably.—Eds.].

*Salicylic Acid.*—General pruritus. Its pathogenesis is incomplete, but many cures have been reported from its use [allopathically].—Eds.].

*Naphthaline.*—The internal use of this drug as a tenuicide and internal antiseptic has produced an insupportable itching. Prof. Bouchard calls attention to this inconvenience which might serve as a homeopathic indication.

*Opium.*—This remedy and, above all, its alkaloid morphine produce a congestive hyperæmia of the skin with generalized pruritus. There is not a physician who has not observed this symptom to follow a hypodermic injection of the alkaloid. The homœopathic doses will give excellent results, as might be expected.

*Rumex Crispus.*—Itching aggravated by cold and ameliorated by heat. Itching of different portions of the body, especially of the lower limbs on undressing. Stinging and itching of the skin. Dr. R. Hughes speaks of its efficaciousness, and Bernard has published a cure from the 12 dec. dilution in an old man of 65 years whose chronic prurigo was of three years' duration. Dr. Searles has found the first dec. dilution of service. The writer has also confirmed these fortunate results.

*Vanilla Odorifera.*—Marked itching, especially of the face and hands, with a sensation of heat, cold or a burning feeling in the skin.

Kafka has succeeded with silica in a case of prurigo with fornication beneath the skin. Mezereum soothes when the itching is nocturnal and insupportable. Mezereum, as well as lycopodium and the iodide of sulphur, are indicated in inveterate cases.—*Ruee Homeopathique Francaise*, No. 6, 1895.

**ATROPINE AND CUPRUM IN TRIGEMINAL NEURALGIA**—Dr Tessier records two cases of trigeminal neuralgia where these two remedies effected a permanent cure.

A male of fifty-four years who, for five years, had been subject to an atrocious trigeminal neuralgia, which was so severe as to interfere both with speaking or eating; even the simple contact of the air with gums and tongue would give him insupportable pain. At night he found it impossible to sleep, as the painful paroxysms would, at times, appear every five minutes. After following various kinds of treatment, he had submitted to resection of the superior maxillary nerve, and later, to a removal of the alveolar portion of the superior maxillary bone. After a treatment of three months with cuprum acetic. 3x and atropine 3x, he was wholly cured. A second case of the same disease in a lady, with identical results after the same remedies, confirms the therapeutic value of these two remedies.—*Journal Homeopathique Belge*, No. 5, vol. ii., 1895.

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## PREPARATORY MEDICAL EDUCATION.

BY F. C. SAGE, M.D., HUDSON, IOWA.

THE question as to what the medical student should know when he enrolls himself a freshman in the medical school of his choice is one of great importance. It has bothered the germinating mind of the student, puzzled his bewildered preceptor, and even embarrassed the philanthropic professor who decides what qualifications should admit him.

In the absence of any uniform requirements among medical colleges as to preparatory work, the easy-going student endeavors to slide in and through with as superficial a knowledge as possible, while the solid student is at a loss just how to become thorough and not dissipate his energies on useless subjects.

Again, the sharp competition among medical colleges and the ambition to increase their enrollment sometimes causes them to admit students with few qualifications beyond their ability to count one. It is a good deal like giving an objectionable dose of morphine to a patient to prevent him going to some one less scrupulous. So with the student; if one col-

lege refuses to open its doors to him, he will go hence to some less scrupulous college, and be admitted without question.

Yet it is worthy of note that our standard colleges are every year becoming more uniform in their requirements for admission, which will greatly facilitate raising the standard of preparatory training to a higher and more commendable plane.

But the purpose of this paper is to point out an ideal preparation for the medical college, and if, perchance, the ideal is thought by some to be too high, it may be answered that the medical profession is one of the most noble of callings, and that if your house be builded upon the sand, the waves of incompetency will wash away its foundation, and it will fall.

To begin, then, with the motto "Hitch your wagon to a star," every intended medical student should, *if possible*, begin at the beginning, and take a thorough college course. This will take time and money. But if we debar genius, is it not, after all, the shortest and surest road to anything much above mediocrity?

It is true there are many young men and women without fortune whom such a requisition might be expected to prevent ever entering the profession. It would, no doubt, exclude some worthy ones. But as far as the writer's experience and observation go, a large per cent. of those who attain their college degree before beginning medical studies proper, are men who have made their own way without outside help, and this when a college course is only advised but not required. How many more could prepare themselves equally well were it compulsory? No doubt it would exclude the one who is always looking for a soft snap. It might also shut out the one who has failed at about everything else and now wishes to try medicine. Yet is there room for this one? Surely not, not at the top. Honest, intelligent effort and anticipated results are at least proportional, if not equal.

It is chimerical and foolish to expect to get something for nothing—to reap without sowing, and he who builds his fortune's framework on such a foundation invites failure.

As to the course of study recommended science undoubtedly has many advantages both as to practical utility and as to the character of the mental discipline acquired. There are no studies that develop the powers of observation and analysis like

the sciences such as physics, chemistry, geology and botany. And while the student is becoming familiar with facts that will be of great use to him as a physician, he is also acquiring a habit of mind and method of thought that must often help him out in the diagnosis of a difficult case and in the application of curative agencies. Chemistry and physiology, it is thought, should be included in the preparatory course, as it is believed they could be better taught there than by the lecture method common to the medical college. In fact, teaching chemistry by the lecture method usually makes the subject so dry that the student acquires a distaste for the science which often clings to him through life.

A more objective and practical method of teaching would, we think, awaken an ever-increasing interest in the subject.

As to languages, a knowledge of Latin is now required in a number of the leading colleges. A good working knowledge of German would be of immense benefit in many ways. There are many splendid openings for the German-speaking homœopath, and it would enable one to read the works of Hahnemann and other German writers in the original, besides being essential to any who might wish to take special work in Germany.

There are many other studies in the scientific course that would be of equal utility to those noted, to say nothing of the prestige it gives one and the benefits, both socially and financially, so that, allowing four or five years for preparation, it is believed that even then the average student will be in as comfortable circumstances in ten years as without the college training, and the chance of subsequent success will be immeasurably augmented. But for those who find it impossible to adopt this plan our State university offers a special two years' course preparatory to the study of medicine. This course is of great value, and a number of students have already taken advantage of it. As to the work the student should do under the direction of the preceptor it can be outlined briefly. In anatomy he should master osteology as thoroughly as possible, as he can do so as well under the direction of a preceptor, if there be a good skeleton at hand, as elsewhere. He should study the articulations in like manner. A general knowledge of the viscera could also be acquired, leaving the muscles, nervous system and bloodvessels till he comes to dissect. In physiology

a general knowledge of the subject could be acquired with propriety, and in this connection some experimental work on the lower animals could be performed with profit. A dissection of a number of dogs or cats would be beneficial.

He ought to read the life of Hahnemann and become well acquainted with the *Organon* and the general principles of the law of cure and the methods of their operation. This would enable him to pursue his studies further under the conviction that he is in the right. It is no less important that he become as familiar as is practicable with the different drugs used, their general appearance and the method of diluting and triturating them, as he may find this work a profitable pastime while waiting for his first patients. Then the lectures in *materia medica* are so much more real if the student knows what is being talked about. It is like hearing of an old acquaintance, and is so much the more easily remembered. There are also the details of office work with which every student should become thoroughly familiar, as it is the little things after all which help to make success. With the preparation that has been indicated, it is believed that any student ought and could complete the medical college course proper in three years. But such a course would be strictly professional, and would not aim to supply the student's necessities by giving him a knowledge of Latin, physics, etc., as some medical colleges are attempting to do. They might as well include reading, writing and orthography if the needs of some students are to be considered. In conclusion, we must not lose sight of the fact that many of the older practitioners, and some of the ablest among them, had little opportunity and less need for the preparation required of the student to-day. They have succeeded nobly without this preparatory training; they might have succeeded still better and have easily filled more responsible positions with it. A few years ago the records showed that only 5 per cent. of the practicing physicians of this country were college graduates. And yet, of the physicians who were found to be locally prominent enough to be worthy of mention by the authors of the *Dictionary of American Biography*, 46 per cent. came from these college graduates. In other words, the 5 per cent. of college graduates furnished 46 per cent. of the prominent physicians. In every line of work the one who succeeds best, as a rule, is

the one who has made the most thorough preparation. Why have so many foreign countries refused to recognize the degrees conferred by our colleges? It is because the time required by our American colleges to obtain the same degree has often been only half as long as in Europe, and the bulk of the difference is in the preparation.

It is claimed that our physicians are more practical. Let them also be more thorough and scientific and have more institutions for original investigation, and they will be able to grapple with the medical problems of the future with the full and abundant measure of success that this advancing age demands. And if homœopathy will fill the high place it is destined to occupy in the future, its exponents must be leaders in the van of progress all along the line that truth may rise, humanity become bettered and that God's unerring natural laws may govern the hearts and minds of men.

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## THE CHEMICAL ANALYSIS OF WATER.

BY CHARLES PLATT, PH.D., F.C.S.

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WHEN bacteriology first became an established science, it was predicted that it would supersede chemistry in all, or nearly all, sanitary investigations. The failure of the chemical test in the demonstration of the specific germ was regarded as fatal, and the microscope was henceforth to rule supreme. Experience has proven the fallacy of such statements, however, and the sometime-rival sciences have joined hands—the true position of each being well defined. The advantages and disadvantages of the two methods, as applied to the examination of water supplies, may be briefly stated as follows: The bacteriological examination of water aims to demonstrate the presence or absence of pathogenetic microbes. Now, aside from the difficulties of identification of germs, when found, the following points are also to be considered: The water supply must be actually infected at the time of examination, and the sample taken must contain the evidence of this infection. The first condition ren-

ders the examination of *ex post facto* importance, confining it practically to the recognition of germs whose presence is already suspected, or which have already been demonstrated by an outbreak of disease. The second condition is by no means easy to satisfy, owing to the segregation of germ life, and the consequent difficulty of obtaining a true sample of a large supply. Finally, while, even in the absence of specific germs, the bacteriological examination will ordinarily detect unfiltered sewage when present, the fact is, that contamination by unfiltered sewage is rare. In the majority of cases, sewage finds its way to the water after filtration through the soil, and this filtered sewage, freed of organic forms, can hardly be detected by the microscope alone.

The chief argument against the chemical examination of water is, as already stated, that it does not demonstrate the pathogenetic microbe. It does something more useful, however; it indicates the presence or absence of pollution in general. It indicates, for instance, the presence of sewage in a supply, and though the pathogenetic microbe be absent, it demonstrates that the road is open for its introduction; thus revealing the danger before the infection is accomplished. It demonstrates the presence of sewage or other pollution, even after filtration, and in entire absence of organized forms. It indicates the nature of the pollution, and, from the condition of the chemical compounds present, the probable interval of time which has elapsed since its introduction; thus serving as a guide to the actual source. Frequently, the analysis leads to the discovery of a remedial cause of pollution, and renders the rectification of a discarded supply possible.

The chemical analysis, then, aims to determine whether a given water is potable or non-potable; whether it may be relied upon as a safe supply, or whether its use will be prejudicial to health. The real difficulty of the examination lies in the lack of standards of pure water, in the necessity of relying upon the chemist for the interpretation of the analysis as well as for its performance. The standard for a subsoil water is different from that for a surface water, or for phreatic waters; while, again, the standards in each of these classes vary with the locality and surrounding conditions. It is necessary that the chemical analysis be conducted by an expert, and that he have

a knowledge of the source of the water. It is not unusual, with ignorant people, seeking an analysis of a water supply, to guard jealously all information as to its source. They argue, probably, that if the chemist were told too much regarding the water he might be prejudiced, and render his report upon the knowledge so gained rather than upon his analysis. This precaution is, of course, ridiculous, and defeats its own end. The chemist is obliged to report without sufficient data with which to interpret his results, and the analysis loses its chief value. If he be cautious, he will, in such a case, report figures alone, and refuse to draw deductions from them.

Summing up, then, what has gone before, we find that both chemical and bacteriological examinations of water have their limitations; that, as regards the question of the potability of the water, chemistry affords the best, and in most cases, the only solution; that, when the question is the presence or absence of some particular disease germ in a given sample, then, bacteriological methods are alone available.

It is my purpose, not to explain the *technique* of water analysis, but rather the manner in which the analysis is reported, and, so far as possible, the methods of interpretation. The analysis itself should be executed by a trained analytical chemist; the various recipes for gauging the purity of a water by means of simple tests are valueless, and the same may be said of the methods of water analysis as taught in many colleges.

For practical sanitary purposes the report upon a water should include the color, odor, taste, total solids, volatile and non-volatile solids, chlorine, nitrogen present as "free ammonia," nitrogen present as "albuminoid ammonia," nitrogen present as nitrites, nitrogen present as nitrates, and, sometimes, the "oxygen consuming power," the phosphates, and the "hardness," both temporary and permanent. According to the habit of the chemist these factors are, when possible, reported either in so many parts per million, in parts per hundred thousand, in grains per U. S. gallon, or in grains per Imperial gallon.\* Now as we have said, there are no definite standards of purity; each water must be considered by itself. There are,

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\* Grains per U. S. gallon  $\div 0.0583 =$  parts per million. Grains per Imperial gallon  $\div 0.07 =$  parts per million.

however, certain general statements possible by which, with due reservation, we can deduce probabilities from the results of analysis even in absence of a knowledge as to conditions.

The three factors, color, odor, and taste, are of importance in deciding upon the palatability of a water rather than upon its potability. The most impure and dangerous waters may be perfectly normal in their physical characteristics, while, on the other hand, hygienically pure water may exhibit a departure from the normal. Occasionally, however, the odor may be recognizable, pointing directly to a gross pollution of one kind or another, or the taste may be so disagreeable as to render the water nauseous, or the color may reveal contamination as from manufacturing waste, etc. Unless there is this positive evidence of definite character the physical examination of water has only a negative value.

The total solids carried by natural waters vary considerably in amount and it is difficult to set any limit which when passed would condemn the supply. Somewhere about 600 parts per million is generally regarded as the maximum allowable but phreatic waters frequently contain more. When the solids dissolved are mineral and in large amount we have practically to deal with a "mineral water" and the potability of the supply must be decided by reference to the nature of the mineral salts dissolved. Organic matter (*i.e.*, volatile solids) of animal origin should not be present; vegetable organic matter is of less moment, but should not be present in large amount. When a turbid water is under examination, it is hardly necessary to say, the dissolved and suspended solids should be reported separately.

Chlorine is nearly always present in the form of sodium chloride. As this substance is a constituent of many soils, and as it is easily soluble, we find it in greater or lesser amount in all natural waters, while in the neighborhood of the sea or of saline deposits it may become excessive. Sodium chloride is also a characteristic constituent of animal excreta and it is because of this fact that the chlorine determination is important from the hygienic standpoint. Natural sources being absent, a large amount of chlorine, particularly when accompanied by considerable organic matter, is indicative of sewage contamination. Indeed even when the organic matter of sewage has been re-

duced and removed by filtration through the soil, the chlorine still remains as an evidence of the former pollution. It is evident, then, that the chlorine is an important factor in our analysis but that deductions from its presence must not be hastily drawn. The chlorine must be considered in relation with the known standards of the particular locality under investigation and also in conjunction with our determinations of organic matter and organic nitrogen. Unless the water has been filtered through a considerable depth of soil, chlorine due to animal pollution will be accompanied by an increase in albuminoid ammonia. It is interesting to note, also, that whereas chlorine from mineral sources will remain remarkably constant from day to day, that from sewage contamination is apt to vary within wide limits. When mineral sources are absent, chlorine exceeding ten parts per million may be regarded as suspicious, but, as we have seen, the other factors must also be taken into consideration.

By the decomposition of albuminoid organic matter various ammonium compounds result. These by oxidation may form nitrates, or, by an intermediate step, nitrites. The reverse change may also take place, and, by reduction, nitrates pass into nitrites or free ammonia. The determination of the nitrogen present in these various forms is of greatest importance in arriving at a knowledge of the water under examination. Standards of nitrogen contents of waters have been fixed by the River's Pollution Commission (British) but, as in the case of chlorine, each sample must be studied by itself.

The "free ammonia" is subject to considerable variation, but when in large amount suggests the possibility of organic contamination. Rain-water may, however, contain a considerable quantity, and so, also, may certain deep waters, where it has probably been formed by reduction of the nitrates. Therefore, while we may place as an upper permissible limit for nitrogen present as free ammonia, 0.2 to 0.5 part per million, the determination has only a relative value unless considered along with the albuminoid ammonia and chlorine. When the nitrogen present as albuminoid ammonia is less than 0.02 part per million the water is generally pure, *i.e.*, free from dangerous organic contamination. A water containing 0.02 to 0.05 part of nitrogen as albuminoid ammonia, other factors being

normal, is regarded generally as satisfactorily pure. An albuminoid ammonia above 0.05 part per million with high free ammonia is suspicious, while with a very low free ammonia the water would still be passable until the albuminoid reaches 0.10 part per million. It is important also to consider the origin of the albuminoid ammonia, whether it is of animal or of vegetable nature. Fortunately we are enabled to decide this point with a satisfactory degree of accuracy from observation in the course of the analysis. Nitrates are evidence of existing fermentative changes and, except in the case of certain deep waters, and sometimes in rain-water, their presence is usually sufficient to condemn the supply. The nitrates represent the final stage in oxidation of the nitrogen compounds. They may be derived from the mineral salts of the soil, or from organic matter, in which latter case they point to a past contamination with subsequent destruction of the organic substance. More than 5 or 6 parts per million is generally regarded as questionable.

The "oxygen consuming power" of a water is hardly a reliable datum upon which to form an opinion as to its character, but it is sometimes included in the form of analysis. A low oxygen consuming power is, of course, desirable. Phosphates are of negative importance; more than 0.60 part per million points to possible contamination from animal excreta, but, on the other hand, phosphates may be absent in a highly polluted water. The "hardness," reported in grains of calcium carbonate per gallon, is not of sanitary importance unless excessive. The temporary hardness, that removable by boiling, is due to carbonates of calcium and magnesium; the permanent hardness, that which cannot be removed by boiling, is due to the sulphates of the same metals.

It is evident then that the correct interpretation of a chemical water analysis is often an exceedingly complicated matter. It is equally true, however, that by one familiar with the subject, reliable deductions can be drawn, and, in fact, that the chemical analysis offers the only known means of arriving at a satisfactory conclusion as to the purity of the water supply.

Much depends upon the collection of the sample taken for analysis, and a few words upon this subject may not be out of place. Glass vessels with ground glass stoppers should be used by preference, and every precaution taken to secure absolute

cleanliness. The bottles, already thoroughly washed, should be rinsed out several times with the water to be analyzed, and then, finally, *filled*, the stoppers fitted and tied. At least one gallon of water should be taken for the analysis. If the sample be taken from a pond or stream it should be from a little below the surface and well out from the shore. If from a faucet, or hydrant, or pump, the water should be allowed to run for sometime before collection, thus avoiding the washings from the pipe. The general surroundings should be noted, the proximity of outhouses, or of barns, the character of the soil, etc., and, if from a well, the depth of the latter. The condition of the weather at the time is often of importance, as the occurrence of heavy rains, or, on the other hand, of protracted droughts will have a marked effect upon the contents of the water. Attention to these points will greatly enhance the value of the chemical analysis, and will amply repay the extra trouble involved.

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## NARCOSIS AND ANÆSTHETICS.

BY A. A. RAMEYER, PH.D., SALT LAKE C.TY., UTAH.

### I.—THE THEORY OF NARCOSIS.

DR. C. L. SCHLEICH, of Berlin, in his recent work *Schmerzlose Operationem* (painless operations), gives a very interesting analysis of the different anæsthetics and their effects on the organism, of which the following is a review.

The effects of the different anæsthetics do not differ so much on account of their chemical than of their physical properties. The quicker a body evaporates, the lower will its boiling point be; the slower it evaporates, the higher that point is. It is evident that a given anæsthetic is more readily taken up by the organism if it is volatile, and that it is the longer retained by it the less tendency to evaporation that anæsthetic possesses; therefore a very volatile anæsthetic is soon eliminated through the respiration, but one which evaporates with difficulty remains longer in the organism, and if its inhalation continues, its accumulation will soon be fraught with danger to life. Herein lies the whole secret of the difference of action

between ether, chloroform, etc. Alcohol boiling at  $78^{\circ}$  C.,\* chloroform at  $65^{\circ}$  C., sulphuric ether at  $34.5^{\circ}$  C., and the human body temperature being  $38^{\circ}$  C., it is now clear why the anaesthesia produced with alcohol is deeper and of longer duration than that produced with chloroform, and with the latter deeper than that obtained with sulphuric ether, all these differences depending on their different degrees of evaporation or, in other words, on their different boiling points.

By mixing together different anaesthetics in different proportions the boiling point of the mixture can be lowered or raised. For instance, by mixing

10 parts of chloroform ( $65^{\circ}$ ) and 10 parts of sulphuric ether ( $34.5^{\circ}$ )	B = $60^{\circ}$ C.
5      "                "      15      "                "      B = $48^{\circ}$ C.	
5      "                "      25      "                "      B = $45^{\circ}$ C.	
5      "                "      40      "                "      B = $40^{\circ}$ C.	
5      "                "      45      "                "      B = $38^{\circ}$ C.	

In the same manner by mixing together 3 parts of chloroform (B =  $65^{\circ}$ ) and 3 parts of æther petrolei (B =  $60^{\circ}$ ) with 7 or 8 parts of æther sulphuricus (B =  $34.5^{\circ}$ ), we obtain a tempered mixture in which B = T; By changing the proportions we can lower or raise the boiling point of the mixture.

In experimenting under glass jars on one lot of animals with the last mentioned mixture, on a second lot with chloroform, and on a third lot with sulphuric ether, to find out the relative advantages or disadvantages between the three anaesthetics, the results were as follows:

1. Those animals which inhaled the anaesthetic (chloroform) of which the boiling point is much higher than the body temperature of the animal (pigeons, T =  $41^{\circ}$ , rabbit  $38^{\circ}$ , cat  $38.5^{\circ}$ ) were narcotized in very few minutes (rabbits 2 to 4 minutes, cats 5 to 8 minutes, pigeons 7 to 10 minutes); the symptoms observed were great excitation, trouble of respiration, opisthotonus, coma, with maximal pupil dilatation.

2. The animals which inhaled the tempered mixture (B = T) were somewhat slower to get under its influence (it took several minutes longer); they presented no period of excitation, little

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\* The Centigrade thermometer scale is used throughout this article. B = boiling point, T = body temperature of the patient or of the animal experimented upon.

or no spasms; the sleep was quiet and of long duration; death took place much later than with the first lot; no untoward symptoms during the anæsthesia; deep, unfrequent respiration, contracted pupil; opisthotonus with pupil dilatation took place only when the coma began.

3. The animals experimented upon with sulphuric ether ( $B < T$ , or boiling point lower than the body temperature) were very slow to get under its influence (20 to 25 minutes more); they showed great jactitation and excitement, frequent and spasmodic respiration, orthopnœ, spasms, rapid coma, death often happening after a very short anæsthesia.

Chloroform produced death the quickest, then ether, but the animals remained alive for the longest period of time under the influence of the tempered mixture (chloroform, æther petrolei and æther sulphuricus). If air was let into the jar during the anæsthesia, or if the animals were taken from under the jar into the atmospheric air, the result was that the animals narcotized with chloroform, in most cases, could not be saved, and those, even the most sensitive rabbits, who had been under the influence of the tempered mixture, could always be restored to life.

The chloroformed animals were the slowest to recover, but the etherized and those that had partaken of the tempered mixture recovered at the same time; those that had been etherized were much more exhausted and did not recover from the coma after it had overtaken them, while those that had been under the influence of the tempered mixture could in most cases be restored to life by artificial respiration.

The post-mortem examination always showed cyanosis of the internal organs, most marked in those killed by ether. The lungs were found as follows:

1. After death by chloroform: Lungs large, containing air, but little blood.

2. After death by the tempered mixture: Lungs atelectatic, slightly œdematosus, containing some air and some venous blood in small quantity; lungs a little smaller than normal.

3. After death by sulphuric ether: marked atelectasis of the lungs, their volume being one-third smaller than normal, showing a dark surface on section, venous hyperæmia, bronchioli strikingly wide, œdema pulmonum, air-bulla lacking altogether.

These experiments teach us that those anaesthetics whose boiling-point is below the body temperature ( $T > B$ , sulph. ether, for instance) pass through the lungs like compressed steam, and hence the pressure causes trouble in the respiration, orthopnoe, cyanosis. Where the temperature of the body and the boiling-point of the anaesthetic are equal or nearly so, the gas is eliminated with the greatest facility by the lungs, while with those anaesthetics whose boiling-point is much higher than the body temperature, the gas is eliminated much more slowly through the respiration.

This explains very well the relative innocuity of ether as compared with chloroform, since the body temperature ( $38^{\circ}$  C.) is as high for the boiling-point of ether ( $34.5^{\circ}$  C.) as  $110^{\circ}$  C. would be for water ( $B = 100^{\circ}$  C.), the chemical combination of ether with the blood cells or the plasma is very loose; for the ether is evaporating under its own pressure, and it takes more time to produce anaesthesia. But all is changed with chloroform; its boiling-point ( $65^{\circ}$  C.) being much higher than the body temperature, it is eliminated by the lungs with much more difficulty than ether, hence its more prompt action (anaesthesia induced in 2–10 minutes, against 20–25 minutes or more for ether). Chloroform being retained, its accumulation may easily take place within the body, hence its danger; and as the lungs are able to eliminate only a portion of the chloroform inhaled, the other eliminatory organs (kidneys and liver) are injured to a large extent by its passage. Terrier claims that albuminuria is produced in two-thirds of all chloroformed persons, while Luther goes even to claim albuminuria in 95 per cent. of all cases. For this reason no albuminuric patient should be chloroformed. But sulphur-ether is not without danger either; for its use often brings about pneumonia, bronchitis, and always cyanosis by the retention of carbon dioxide, through over-pressure of the evaporating gas in the bronchioli.

The different effects of the various anaesthetics are noticeable not only after inhalation, but also after hypodermic injection. By injecting two grammes of chloroform into a pigeon, two grammes of sulph. ether into another and two grammes of the tempered mixture (chloroform, æther petrolei and æther sulphuricus) into a third one, the sulph. ether, according to its violent effects, would appear to be the greatest poison (chemi-

cally), which, however, it is not; the animal is struck down, its respiration is exceedingly quick and it shows opisthotonus and maximal pupil dilatation; chloroform, in hypodermical injection, does not produce any similar effects; the mixture of chloroform, æther petrolei and æther sulphuricus, whose boiling point has been brought down to 41° (body temperature of the pigeon), does not cause any untoward symptoms as ether, although this mixture contains 90 per cent ether; the animal falls slowly over, without any respiratory disturbance. No chemical explanation is needed to decipher such different effects, the simple physical phenomenon of evaporation at various boiling points (chloroform 65°, ether 34.5°, and the mixture tempered down to 41°) accounts for all the difference; the organism eliminates without any disturbance the anæsthetic whose boiling point is nearest to its own temperature, while the sulph. ether ( $B = 34.5^\circ$ ) evaporates at once at the body temperature of the pigeon ( $T = 41^\circ$ ) and rushes through the lungs with such pressure that the carbon dioxide is kept back in totality, producing cyanosis, spasms, overpressure in the lungs; these become unable to receive the arterial blood, which remains in the left heart, causing rapid death from asphyxia.

## II.—NEW METHOD FOR NARCOSIS.

Schleich has put his ideas into practice in sixty-five cases, using the above-tempered mixture, as he calls it, which he prepares in this way: equal parts of æther petrolei ( $B = 60^\circ$ ) and of chloroform ( $65^\circ$ ) are kept in dark bottles. In another bottle with two necks he puts a certain quantity of sulphuric ether ( $B = 34.5^\circ$ ) which is brought to ebullition in the wet bath,\* and then he adds chloroform and æther petrolei until the boiling point of the mixture is brought to the desired mark ( $37^\circ - 45^\circ$ ); he keeps ready for use a number of bottles filled with mixtures of which the boiling point varies from  $35^\circ$  to  $45^\circ$  C. When he wants to operate with the anæsthesia, he finds out the temperature of the patient's body and then selects a mixture of

\* It is very difficult to give an exact proportion of the different anæsthetics, because a portion of the ether evaporates during the ebullition; the temperature of the wet bath must be only a few degrees above the desired boiling point as otherwise the anæsthetics fail to combine, and if once overheated the mixture is spoiled.

which the boiling point corresponds with the ascertained temperature or a mixture of which the boiling point is  $3^{\circ}$  or  $4^{\circ}$  higher, according as he wants a sleep of short or of long duration. In this manner, he has it in his power to get his patients conscious immediately after the operation; for, by using an anaesthetic of which the boiling point is equal to the body temperature, the patient awakes almost immediately after withdrawing the anaesthetic; so easy is it for the mixture to evaporate from the lungs; but if an anaesthesia of longer duration is desired, a mixture of a higher boiling point is selected because of the slower elimination, thereby producing a deeper sleep. The beginning of the anaesthesia depends also on the boiling point of the mixture; if  $B = T$ , it takes less time to induce sleep than with sulphuric ether, but longer than with chloroform.

Schleich uses a simple chloroform mask, covered with rubber cloth and containing cotton balls soaked with the mixture. When  $B > T$  the quantities used were smaller than when  $B = T$ . The largest quantity ever used by him was 150 grammes and that for a complicated uterus extirpation lasting nearly one hour and a half.

The advantages claimed by the new method are as follows: the stage of excitation was but little marked even in three habitual drinkers, and otherwise was nearly always lacking; full anaesthesia (total analgesia) was always obtained, children and old persons being no exceptions; in gynaecological operations the abdominal walls were always relaxed; cyanosis never appeared; vomiting was as frequent as with ether or chloroform, but certainly not more; ptyalism or bronchitis were never observed; a child brought in a very dyspnoeic condition for tracheotomy sustained the anaesthesia very well and remained alive.

The English A. C. E. mixture (alcohol, 1; chloroform, 2; ether, 3 parts); the favorite anaesthetic at Guy's and at most of the London hospitals, is an instinctive step in the right direction, for this mixture boils at  $50-53^{\circ}$  C., viz.:  $15^{\circ}$  nearer the body temperature than chloroform alone; chloroform and ether in the proportion of 1 : 9 boils at  $38^{\circ}$ ; in the proportion of 1 : 8 at  $40^{\circ}$ ; and in the proportion of 1 : 5 at  $45^{\circ}$ . Experiments might be made in this line too.

Schleich prefers adding æther petrolei to his mixture because

he found in his experiments on animals that no other anæsthetic can be injected hypodermically in such large quantity without untoward effects; he considers it the best substance to mitigate the action of chloroform.

#### How to ADMINISTER ANÆSTHETICS.

1. Make yourself acquainted with the pulse, the respiration, and the pupil (contraction and dilatation) of your patient before you give him any anæsthetic.
2. Give cautiously and sparingly a small dose of the anæsthetic with air, frequently taking off the mask and watch the effect on pulse, respiration and pupil (don't touch the cornea with the finger); any signs of altered respiration and pulse or the sudden change of the pupil from contraction to dilatation, or *vice versa*, indicates danger (threatened paralysis) on account of an idiosyncrasy of the patient, the anæsthetic must be withdrawn; fainting is an ominous symptom to. If the pupil movements are normal and the respiration regular and the contraction of the heart continues with the same energy, the anæsthetic can be further given without danger.
3. When the pupil gradually contracts it is a sign that the anæsthetic sleep begins; at this stage the patient can be awaked as in the physiological sleep by calling him. The stage of excitation passes off, the reflexes are absent and the operation may begin.
4. By further administering the anæsthetic the contracted pupil gradually enlarges; now is the time to watch with the greatest attention, for here lies the great secret of correct and successful anæsthesia; and the movements of the pupil give the key to the whole situation. By carefully giving more of the anæsthetic, the pupil begins to enlarge, viz., the toxic influence of the anæsthetic reaches over to the sympathetic nerve; its irritation (extreme pupil dilatation) would soon be followed by its paralysis (extreme pupil contraction), and at the same time the medullar centres for heart and lungs would be affected. Therefore it is most important not to overdose the medulla; any sudden change of the pupil from extreme contraction to extreme dilatation or *vice versa* is a sign of great danger. *The pupil must be kept in a middle position between contraction and dilatation, and herein is security.*

When the patient vomits, the pupil dilates also; but if, immediately before the vomiting, the pupil was contracted, more anaesthetic may safely be given; it will stop the vomiting, for it is a reflex showing that the patient begins to awake; but if the pupil was in middle position between contraction and dilation just before the vomiting, it is a sign of irritation of the medulla and giving more of the anaesthetic would have the worst results; let the vomiting go on and give no anaesthetic until the pupil stands again between dilatation and contraction.

There is still a third possibility for the pupil to be widely dilated, viz., on account of reflex irritation from the periphery, while operating in the peritoneal cavity for instance.

5. The atypic sudden dilatation or contraction of the pupil from the first; further, the sudden failing of the strength of the pulse with increased frequency, and thirdly the change of facial expression from an anxious countenance to one of apathy and of depressed features are signs of near danger; the anaesthetic shows its toxic influence on the centres of the medulla, and should be put away at once and fresh air admitted. Hence it is very important to look often at the face of the patient and watch its expression.

The above considerations are not theoretical but practical since they come from a surgeon who has for several years administered chloroform from three to six times daily in the largest clinics of Berlin, hence he speaks from experience.

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#### CONVULSIONS IN CHILDHOOD, WITH ILLUSTRATIVE CASES.

BY EDWIN H. VAN DEUSEN, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

I WISH to present this evening some cases and some comments. Instead of following the customary plan of making my argument first and then presenting my cases, I shall follow somewhat the plan of the popular lantern lecturer and show my pictures first and talk a little about each as they are fresh before you, lapsing into a possibly more classical form at the end of the panorama.

CASE I. is a girl of three years, the fourth child of a mother who had pulmonary phthisis before she was married, but which had been arrested in its course. (I speak advisedly, for I have since seen the apices of her lungs.) The father had haemorrhages ten years before, and was the only remaining member of his family, his brothers and sisters having all died of pulmonary phthisis and his mother of cancer. This child, one afternoon, after having been listless for an hour or so, suddenly fell into a violent general convulsion, which lasted about a half hour. The physician knew the family history, and pronounced the case to be tubercular meningitis, and announced a hopeless prognosis. The child the next day was apparently as bright as ever. Some ten days later the same round of symptoms occurred, with this noteworthy exception: at the close of the convulsion, after the departure of the physician, the child vomited, among other things, some small bits of raw ham. Some two weeks later the doctor was again summoned to witness the same series of phenomena. The vomiting occurred while he was present. Raw ham was present also. He read a lecture upon the pernicious habit of permitting children to eat ham, especially raw, and various other things, among which he mentioned oranges as being particularly harmful, saying that one orange could do more damage than a whole dozen bananas. The lecturer may have been mistaken, but the lecture had the desired effect, namely, no more ham, no more fits, and that was twenty years ago.

This case, of course, I did not treat. It is, however, one of the traditions of the family; and since I have treated the family for fifteen years, I feel as if I owned the case. It is illustrative of other points, but I mention it chiefly to attract attention to the fact that the family history alone, even when very strongly marked, is not a safe guide to a diagnosis in convulsions.

CASE II. is a boy, a first child. When he was six months old he had no teeth. A little acquaintance of his, two days younger, had six teeth. Some admiring friends and relations advised that he have stronger food. In spite of professional counsel to the contrary, he had it. When he was sixteen months old he had six teeth. The acquaintance, who lived chiefly on milk, had sixteen teeth. The strong feeding went

on. The child seemed to have the digestion of a goat. He ate everything, including fried oysters, canned corn, ham and veal, without his stomach giving expression to any evidence of astonishment, much less resentment. He did not seem to have the slightest sense of indigestion. Shortly after his fourth birthday, without any warning, according to his mother's report, he was violently convulsed. The violence of the seizure gradually abated, and in fifteen or twenty minutes the child was quiet. He had had a good movement from the bowels a few hours before, had been perfectly regular for weeks, and had eaten nothing, absolutely nothing, except some crackers and milk. This was the report of his mother, an intelligent, educated and truthful woman. Within an hour the child had another seizure, more violent and lasting longer than the first. I then ordered full enemas and gave a purge. In somewhat more than an hour another convulsion occurred. The enema had not been given because the mother knew there could be nothing in the bowels. After the convulsive movements had somewhat subsided, I gave several full enemas, and was rewarded by a large movement from the bowels, consisting of faecal matter, unchewed canned corn in considerable quantity and a dozen or more chunks of veal cutlet almost unchanged in their passage from the lips to the anus. The mother was astonished, and affirmed that this had been eaten two days before, and that for thirty-six hours the child had not eaten or wanted anything but crackers and milk.

This case illustrates, with considerable force, the fact that the whole system will often tolerate abuses (especially through the digestive apparatus) for a considerable length of time, when there may occur an explosion often altogether out of proportion to any recent offence. The indiscriminate feeding of children is a dangerous thing. It is especially delusive when the child has been either underfed, or, sufficiently fed, upon a too restricted diet; for then, for a considerable period of time, there often is a real improvement in the general health; but, a day of reckoning and recompense comes, even if delayed for years.

CASE III., is a boy of ten months, who was under treatment for catarrhal bronchitis. For several days he had been improving nicely. One morning, his nurse noticed that his baby-trick of pushing with his feet while lying on his back, and bow-

ing his body up from the bed, was very much exaggerated. On more careful examination, it was found that he frequently threw his head backward into the pillow and rolled it from side to side, at the same time rolling the eyes upward until the iris was covered beneath the upper lid. At such times, the conjunctiva was insensitive. Two years before, this child's mother had lost a baby less than a year old with what was supposed to be brain trouble. Consequently, the alarm was great. A prominent and able physician was called in counsel, and he expressed the opinion that the disease was *probably* tubercular meningitis, and the prognosis, of course, very grave. Under *belladonna* the irregular movements subsided, and the child made a slow recovery, having considerable bowel-disturbance, and cutting three teeth during convalescence. Of course, this case was not meningitis, tubercular or otherwise. There was no history of an injury. The bowel-disturbance was largely the result of the efforts to find a suitable food. The ill-developed convulsive tendency was probably due to either dentition or incipient rachitis, or both. A diagnosis, under such circumstances, must be merely tentative. It is unfortunate, that custom demands of a consultant a definite and positive statement; for often, when the diagnosis is really in doubt, he feels called upon to mention unfortunate possibilities, which are then usually accepted by the friends and relatives as certainties—mentioned as possibilities merely to soften the blow.

CASE IV. is a bright little girl of five years, the fourth child of a father who was successively a student in the Harvard Law School, a lawyer, a singer in light opera and church choir, a ballad singer in a minstrel troupe, and all the time a periodical hard drinker. Her mother was successively an Amherst graduate, the proud wife of a handsome man, a woman broken in spirit, a household drudge, bound to her husband only by ties of affection for her children, and the ties of a marriage in the eye of the law. This little girl was very bright, very pretty, of a lovable disposition, and very nervous. She suffered from oxyures to an intolerable degree. After exhausting all the ordinary means, rectal injections of carbolic acid were determined upon. I will not pretend to tell you the exact strength, for, in my notes of the case, I have neglected to mention it. I thought, at the time, it was very weak, and I expected to make

it much stronger, but I did not. I had a wholsome regard for carbolic acid, having had a case of poisoning with it, which convinced me that in the rapidity of its action it was second only to prussic acid. I first washed out the rectum with large injections of warm water. Then I injected two ounces of the carbolic acid solution, which was retained a few minutes and then expelled. I then injected four ounces, which was retained a few minutes and then expelled more or less completely. I was about to make a more liberal injection, when the child began to make a peculiar rhythmic noise, neither a laugh nor a cry, yet savoring of both. Her mother became very much alarmed and excited, and picked the child up in her arms. Then rhythmic movements began, flinging of the head and trunk and arms backward and forward, the peculiar sounds continuing. Within a short time, the movements and sounds had gradually subsided, and a period of alarming collapse set in. The face was ghastly pale, the skin was cold, the breathing shallow, the pulse almost imperceptible. The bowel was freely flushed with warm water. Artificial heat and brandy were freely used. In a half-hour color was returning, the breathing was quite natural, and the pulse, though weak, was of a character to inspire confidence. It was forty-eight hours before the extreme prostration had subsided, and a week before she had recovered her vivacity.

This outbreak was probably the result of worms, hysteria and carbolic acid. The irritation of the worms increased the nervous susceptibility of a naturally over-modest child, already very excitable by inheritance, to a degree sufficient to render the injection and necessary exposure a sufficient cause for a hysterical outbreak. The carbolic acid probably aided in the production of the convulsions and was the prime factor in the following collapse and exhaustion. A little more careful attention to this child's temperament would have saved her this disturbance. It is of the utmost importance in treating such cases not merely to name the disease and prescribe for it, but also to take into careful consideration that combination of characteristics which is called the patient, in an *individual* as well as in a general sense. But it is much easier to write history than prophecy, and this is the reason that hindsight is a gift so much more common than foresight.

CASE V. is another little girl about 5 years old. She had had scarlet fever a year before, with dropsy following, from which she seemed to entirely recover. One summer morning, as she sat in the back doorway, she complained to her mother of feeling queer. A few minutes later she tried to rise, and fell over to the right side and seemed to have a slight convulsion. She quickly recovered and vomited undigested food. While unnaturally quiet, nothing particular was noted for nearly two hours, when she had a very appreciable convolution, and again fell toward the right side. She soon partly recovered consciousness, and seemed to have difficulty in moving the right hand and arm. She vomited copiously. As consciousness became more complete, the power of motion seemed to be restored. The urine, on examination, was found to be very albuminous, and it was learned that for some weeks the secretion had been scanty. A third convolution occurred some hours later, and recovery of consciousness was less complete. Loss of power in the right arm became marked and extended to the right leg. The vomiting continued. In forty-eight hours speech also was impaired. The child became comatose, and died on the fourth day. The autopsy revealed advanced kidney and arterial changes and a clot an inch and a quarter long extending to the surface of the brain at the lower end of the fissure of Rolando on the left side. It is only fair to Dr. Bartlett to say that he had accurately localized the brain lesion several days before death. The rarity of cases like this, and the excellent opportunity for mistakes in diagnosis early in the progress of such a case, are sufficient reasons for its presentation.

CASE VI. is a girl 8 years old, who was very much debilitated by phthisis pulmonum. While sitting in her high chair eating, she suddenly became convulsed. Much difficulty was experienced in getting her out of her chair, the motions were so violent. She continued in general clonic convulsions from 6 o'clock in the evening until after 11 o'clock at night. The intensity varied somewhat until after 10 o'clock, when the violence began to abate, and all movement had ceased soon after 11 o'clock. The pulse had become scarcely perceptible and the breathing was shallow. In the morning I turned over in my mind the question of filling out a burial certificate, and decided that there was no hurry. At 12 o'clock noon I found

the patient sitting in her high chair eating bread and molasses. Her phthisis pulmonum progressed uneventfully, and she died about two months later.

She had lumbricoid worms. There seemed to be no other cause for the seizure. At 9 o'clock, during the convulsion, she received hypodermically  $\frac{1}{100}$  gr. of physostigmine sulph., and a repetition of the dose at 10 o'clock. The physostigmine seemed to be markedly beneficial. What she received during the first couple of hours of the seizure I do not know. The case was given up by an old-school brother as one of hopeless tubercular meningitis.

The last physician called to a case has an immense advantage. He has all the light his predecessors have been able to shed upon the subject and he comes to the case with an unprejudiced mind. Then too if the patient gets well great is his glory even if his predecessors actually deserve the credit, and if the patient dies it only what is to be expected.

CASE VII., is a sturdy rugged boy of some seven years. A gentleman, whose daughter had died of diphtheria some four weeks previously, was visiting the home of this boy and the two became very close and affectionate friends. On the following Wednesday the boy fell head foremost from a peach tree, alighting on his head in a freshly dug flower bed with such force as to jar his rubber shoes from his feet. He struggled to his feet half laughing and half crying and ran around in a circle. A gentleman passing caught him as he was about to fall and after supporting him a few minutes his boy friends helped him home, a distance of about two hundred yards. He made no complaints and the next day played as usual. In the evening he was listless. Friday morning he had fever and there were dirty white patches on his tonsils. They extended rapidly, covering the half arches, the posterior pharyngeal wall and the posterior nares. The breath became offensive and the discharges from the nose and throat profuse. On Saturday he became delirious. During Saturday night he became comatose and died in a convulsion at 12 o'clock noon on Sunday. Diphtheria was written in the certificate as the cause of death but it is more than likely that his fall was responsible for the coma and convulsion and his early decease.

CASE VIII., is a baby four months old who was wearing plas-

ter bandages on both feet to correct talipes. He was apparently otherwise in perfect health. About 5 o'clock one afternoon he was suddenly convulsed and for thirty-five minutes the muscles all over the body were alternately contracted and relaxed. The baby had a restless night but seemed to be sleeping quietly in the morning, when suddenly the convolution was renewed. This time it continued with varying intensity from before 11 until after 2 o'clock. During the seizure the plaster bandages were removed and a small red spot was noticed at the fold of the skin across the left instep. By the next morning the lower portion of the leg was a deep red bounded by a sharp line of demarcation half way up the calf. There was no other discoverable cause for the convulsions. During the second convolution chloroform was used sufficiently to subdue the violence of the attack. At about 1 o'clock  $\frac{1}{10}$  gr. of physostigmine sulphate was administered hypodermatically and the dose was repeated every twenty minutes until  $\frac{1}{5}$  gr. had been given.

A point worthy of consideration in this case is that a short time before the birth of this child his mother, while in the cellar had the misfortune to have her clothing catch fire. In an instant the flames blazed up about her and must have done serious damage but for her cousin who quickly smothered the flames. The mother perfectly realized her danger but while the incident was startling it did not appear to make an intensely profound impression upon her. The relation sustained by this incident to the convolution is conjectural. Erysipelas is not commonly introduced with convulsions, even in childhood. Probably the irritation of the cast was another element in the causation.\*

A convolution is always the result of either exaggerated excitation of a motor centre or diminished inhibitory power, or both. The excitation may be direct or reflex. The motor centre may be more or less irritable, when a proportionately less or greater degree of excitation will be necessary to produce a convolution. The motor centre may be able to sustain a resistance to exciting influences for a considerable length of time, and then suddenly give up, and a convolution occurs, and con-

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\* This child has since died during a convolution reported to have occurred suddenly and without apparent cause while he was apparently in robust health. The fatal convolution occurred six months after those reported.

tinues until the exciting influence is removed or annulled by either a diminution of the irritability of the centre, or an increase of the inhibitory power.

In infancy and early childhood the irritability of the motor centres is decidedly greater than later in life, and the inhibitory power is often undeveloped. For this reason convulsions are common in the earlier years of life. They often result from apparently very slight causes, such as the irritation from teething, fright and other emotions. They often usher in acute diseases, taking the place of what, in an older person, would be a chill or even a less violent manifestation. The convulsive susceptibility differs materially not only in individuals, but also in families. It may be inherited from neurotic parents or developed in utero as the result of strong nervous impressions made upon the mother, or acquired after birth.

Convulsions in children are nearly always symptomatic. Occasionally a case without a discoverable cause must be reported as eclampsia. Probably an autopsy would alter the diagnosis. Epilepsy, chorea and semi-occasionally a hysterical convulsion complete the list of general idiopathic convulsions in children.

Meningitis and cerebral effusions, various acute diseases, some poisonous drugs, and last, but not least, reflex irritation, either dental or gastro-intestinal; these are the causes of most of the convulsions under twelve years of age. The diagnosis of convulsions at this age is so simple that the physician is usually expected simply to confirm the diagnosis made before his arrival. The only serious obstacle to the diagnosis of convulsions in adults is malingering, and feigning convulsions is too hard a task for a child to undertake. Difficulty arises when a cause for the convulsion is sought. It is usually unsafe to express a definite opinion during the initial attack. Perhaps in 80 per cent. of the cases the convulsions will be found to be reflex; but even if indigestion exists and dentition is progressing, there may be a deeper cause acting at the same time. The convulsive seizure in itself often presents nothing characteristic of any lesion or source of reflex irritation. The antecedent history is frequently unreliable. Anxious friends and relations are usually very poor observers. There is frequently no recollection of anything indigestible having been eaten until the child passes the undigested food by the mouth or anus. In-

juries to the head are often falsely denied for obvious reasons. When the convulsion is the initial symptom in an acute disease there is no antecedent history of any value. This fact alone is often a fair index of the advent of an acute disease.

Very young children do not point symptoms to their location. They are fretful and irritable from pain, and the irritability is little varied by pain in the head or heels, or midway.

I saw a baby some years ago who was very fretful; would not nurse and kept rubbing his nose almost constantly as if it was a great source of annoyance. The mother informed me that she thought the child had worms and asked if that caused the fretfulness. I replied that it was very probable. A few days later I heard indirectly from the father of the child that I was a h— of a physician not to know the difference between worms and earache. This opinion was prompted by an old-school friend of mine whose acuteness of perception enabled him to make a diagnosis of earache merely from seeing a discharge from the ear. Just so with convulsions in children. When it is all over and the returns are all in it is almost as difficult to make a mistake as it was in the beginning to be sure of a correct diagnosis.

It is an extremely difficult thing to come to a definite and accurate conclusion concerning the action of a remedy in any given case of convulsions. For instance, bell. is given to a child who seems about to be convulsed and the convulsion does not occur. Who is to blame—the child or the remedy? I do not know. Or suppose the convulsion has occurred and bell., hyos., nux, ign., cuprum, zincum, opium, cham., lach., cicuta, or any other of the remedies ever mentioned for convulsion, is given and the convulsion quickly subsides and does not recur. Can one conclude that the remedy produced this effect? I think not if the conclusion is based upon one case only. And yet I wish to make some comments concerning three remedies in the treatment of convulsions. If I had seen the supposed effect in only one case I would not say a word. Perhaps not after two. But after several similar cases the phrase *post hoc propter hoc* gains force, and a conviction born of the observations of events all in harmony steals upon one, and an opinion, the result of experience, is formed.

Belladonna seems to me to rank far above any other remedy

as a prophylactic and a curative remedy in convulsions. This is experience, empiricism if you wish. The physiological action of the drug and the pathogenesis (by which I mean the action of the drug upon healthy human beings homœopathically stated) both point strongly in this direction. This is homœopathy. Empiricism is simply homœopathy verified. I am not advocating the indiscriminate use of belladonna in convulsions, but only stating that in my experience it is more frequently called for than in any other remedy and that where indicated its action is most prompt and gratifying.

I shall mention only one other usual remedy, and that rather as a text for a word of warning than of commendation. Except in convulsions from intestinal irritation, *nux vomica*, even when seemingly well-indicated, has often been disappointing and sometimes harmful in its effects. I have never known it to work anything but mischief when the convulsion is symptomatic of an approaching acute disease. In intestinal irritation or indigestion when indicated its effects are admirable.

Physostigmine was mentioned in connection with two of the cases to permit the introduction of a statement concerning its use. In some apparently desperate cases it has seemed to produce brilliant results. In no case has there been any harmful after-effect. Its selection has always been made as a last resort and after the failure of other remedies to produce any improvement. It has always been administered hypodermatically and in a dose of  $\frac{1}{100}$  gr., repeated from one to three times.

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#### THE TOXIC EFFECTS OF TOBACCO.

BY GEO. W. CROCK, M.D., VICKSBURG, MISS.

THE effects produced by the use or administration of tobacco in any of its forms are almost entirely due to the action of its active principle, nicotine.

The alkaloid receives its name from *nicotiana*, the botanical name of tobacco, so called in honor of Jean Nicot, a French diplomatist, who, in 1560, sent the seeds to France from Portugal as those of a highly medicinal plant.

It has been considered that tobacco smoke owed very little

of its potency to nicotine and more to various combustion products; but as the effects of these vary only in degree from those produced by nicotine, being milder and less rapid in their toxic effects, the symptoms produced are usually considered as due to the nicotine present. As the result of a general acceptance of this idea it has been the effort of some tobacco growers to cultivate the aromatic properties and diminish the nicotine.

The percentage of nicotine present in tobacco varies so largely, according to the different localities in which it is grown, and the methods of curing and analysis differ so materially in the results of their investigation that it is impossible to give a definite statement of the percentage of nicotine found in the prepared leaf. It varies from 2 to 8 per cent.

*Adulterations.*—Various adulterations are used in preparing tobacco in its different forms; but they, while not entirely inert by any means, play but a very small part in the toxic results of its use. Molasses, liquorice, figs and glycerine are used to impart a sweet taste and to prevent rapid drying. Common salts and other salts are used for flavoring, and nitrate of potash or soda is sometimes added to increase the combustibility of tobacco used for the manufacture of cigars or for smoking tobacco. Anise and other aromatics are used for their flavor, and smoking tobaccos have their odor increased by the use of cascarilla bark and Tonqua bean, which is also used in scenting snuffs. These additions, except those for odor, are made in the form of a liquor in which the leaves are steeped. Lime is sometimes mixed with snuffs to increase their dryness, and these, of course, have an irritating effect on the mucous membrane of the nasal passages or gums, according to the method of its use.

*Nicotine, C<sub>10</sub>H<sub>14</sub>N<sub>2</sub>.*—This alkaloid was first isolated by Posselt and Reimann in 1828, and is a colorless, transparent liquid having a strong tobacco odor, which is increased by the application of heat. It has a sharp burning taste, and is very soluble in water, alcohol, ether, turpentine and fatty oils.

*Toxic Effects.*—The symptoms of poisoning by tobacco are, primarily, nausea, vomiting and deathly pallor. The body becomes bathed in a clammy sweat, the surface is cold, respiration is quickened and occasionally followed by tetanus of the mus-

cles of inspiration. The pupils are contracted, which is a curious fact in view of the well-known dilatation produced by belladonna, stramonium, hyoscyamus and others of the solanaceæ. The secretion of bile and saliva is increased, and there is a contraction of the entire intestinal tract. If the dose of nicotine be not sufficiently large to produce a fatal result, secondary symptoms may appear months or even years after beginning the habitual use of the weed. These may be any of the following: granular inflammation of the fauces and pharynx; possibly from atrophy of the retina there will be loss or diminution of the power of sight, without any external appearance of the organ being affected; there may be various cardiac symptoms; the heart is dilated, and there is frequent pallor or a livid countenance, aberrations of the sense of sight with appearances of imaginary objects, a dry cardiac cough; pains as of angina pectoris are frequently present, shooting from the heart up to the shoulder and down the left arm or up into the neck; cold extremities, palpitations, feeble and irregular pulse, insomnia and diarrhoea alternating with constipation; facial neuralgia may exist, and the tongue will have habitually a thick whitish coating, and there may be marked irritation of the entire intestinal tract; chronic dyspepsia is frequently seen in tobacco users, caused by the waste of saliva which should be used in digestion.

*Action.*—Nicotine is very readily absorbed by the mucous and cutaneous surfaces, particularly if the continuity of either be broken. Its ready absorption is easily understood when it is known that fatal symptoms have developed from the mere inhalation of tobacco smoke, a condition in which but a small percentage of nicotine comes in actual contact with the mucous surface.

The primary action of the drug on the spinal cord is exciting, and, in fatal cases, death is due to a rapid paralysis of the respiratory centre, without previous excitement, and never due to heart paralysis. Although the heart is markedly affected, the drug does not act on the cardiac muscular structure directly.

Large doses of nicotine cause convulsions both tonic and clonic. The brain may be paralyzed, producing loss of consciousness or loss of voluntary movements after a more or less

brief interval of excitement, followed by general paralysis, the spinal cord becoming insensible to irritation from affection of the gray matter of the anterior cornua.

*Temperature.*—The lowering of the superficial temperature is due to paralysis of the vaso-motor nerves.

*Destruction.*—It has not been definitely proven that nicotine is destroyed or diminished in any degree by the excretions, but it is supposed to be destroyed in part by the action of the kidneys and saliva.

*Snuff.*—Tobacco in this form is probably less productive of toxic effects than any other, whether inhaled into the nostrils or applied to the gums in "dipping," as small quantities are used in either case, and there is very little nicotine absorbed. Its use in this form causes redness and some swelling of the mucous membrane, and will, after continued use, result in a hypertrophy of the membrane, particularly if used in the nasal passages, and a consequent loss of activity of the olfactory sense.

*Cigars and Pipes.*—It is in the use of cigars and plug tobacco, either for chewing or smoking, or the use of granulated tobacco in pipes, that produces the most toxic symptoms. In these cases the effect is produced by the absorption of the tobacco in solution, or the nicotine is absorbed from the smoke.

In cigars, the effect comes not only from the partial inhalation of the smoke, but also from tobacco in solution, as the tip of the cigar is moistened by the saliva, and lies in contact with the mucous membrane of the mouth during smoking.

*Cigarettes.*—The use of these has been condemned as not only the most injurious form in which tobacco can be used, but by some is considered a vice parallel to the use of opium or cocaine. Now, while this is certainly an extreme view, there is no doubt that their habitual use occasionally leads to disastrous results.

In the use of cigarettes the effects are produced by the complete inhalation of the smoke, and in their use the adulterants have more effect than in any of the other forms of tobacco.

In the cheaper grades of cigarettes the lack of natural quality in the tobacco is made up by the use of the various adulter-

ants mentioned; and where the indulgence is excessive, particularly in the growing young, the effects are most marked.

Some effect is produced, too, from the inhalation of the burning paper, particularly if poisonous bleaching agents have been used in its manufacture.

*Toxic Dose.*—This varies from the small amount absorbed by the individual who smokes his first cigar or takes his first chew to the quantities that have been taken with suicidal intent or administered for therapeutic or criminal purposes. There are very few cases of poisoning by the pure alkaloid. One is interesting as it is the first instance in which a pure alkaloid was used for criminal purposes. This was the poisoning of M. Fougines by Count Bocarmé and his wife. Another case is on record in which an individual took it for the purpose of suicide. The quantity used in either of these cases is unknown. The amount of nicotine necessary to produce the primary symptoms of poisoning in an individual using tobacco for the first time is, of course, small, and the degree of tolerance acquired by habitual users of the weed will vary according to the length of time they have been addicted to its use, the percentage of nicotine present in the particular brand of tobacco used, and the form in which they use it.

It is apparent that a chewer can acquire a greater degree of tolerance to nicotine than a smoker, as it is so much more readily absorbed when in solution with the saliva, and enters the system in greater quantities. In a smoker the effects are produced by the mere contact of the tobacco smoke with the mucous membrane by inhalation, which is partial when the smoke is only drawn into the mouth, and complete when drawn into the lungs, excepting in the case of the cigar smoker, where some of the tobacco is in solution from the contact of the cigar with the tongue and saliva. Nicotine is one of the most violent poisons known to chemistry, and in doses sufficiently large to act fatally its action is very similar to that of hydrocyanic acid. On the lower mammalia its action is just as rapid and as surely fatal as Prussic acid and almost equally so in man.

The fatal results that have come from smoking tobacco are probably due to the inhalation of the smoke and its consequent direct contact with the moist mucous lining of the lungs, by which the nicotine is readily absorbed. Death has followed

the administration of a decoction of tobacco leaves in enema, either for therapeutic or criminal purposes, and also from its use as a local application to the skin, thus showing that its application in solution is favorable to very rapid absorption.

The effect of nicotine is practically the same as that of tobacco in solution, merely differing in degree.

*Dose.*—Tobacco infusion has been administered in enema in doses of from 5ss to 3ij, but toxic symptoms have resulted from much less than this maximum. In many instances a dose of 3j would be sufficient to produce marked toxic symptoms. By the mouth five or six grains of tobacco are emetic, and anything more will be likely to prove toxic. The alkaloid is so rarely used in therapeutics that it is impossible to tell just what a fatal dose would be, but one-tenth of a grain or over would probably produce very severe symptoms.

*Post-mortem Appearances.*—None are known which can be directly attributed to nicotine or tobacco alone.

The signs of death from the action of the poison on the lungs have usually been observed. If tobacco has been swallowed in sufficient quantities to act fatally, there will exist some redness of the stomach and intestine. An analysis of the contents of the stomach would detect the presence of the alkaloid where it had been swallowed.

*Antidote.*—Strychnia,  $\frac{1}{16}$  grain of the nitrate subcutaneously, or from 10 to 15 minims of tincture of nux vomica by the mouth.

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## SUMMER HOMES IN THE COUNTRY.

BY W. S. SEARLE, M.D., BROOKLYN, N. Y.

IT is probably not an extravagant statement that, during the hot months of the North American summer, half a million persons leave the prospective "Greater New York" for a more or less protracted sojourn in the country. Most other cities, especially those upon the sea-coast, experience a similar depletion, in proportionate measure, while even the larger villages, in a varying degree, are thus depopulated. This is a social phenomenon which has rapidly developed during the last twenty-five years, and its present extent is unique in national history.

Watering places (so called), springs of various descriptions, mountain and sea-side resorts, half a century ago, there were for the rich and fashionable: sportsmen hunted and fished, as now; and family mansions were to some extent revisited. But to-day the country has become one vast summer boarding-house, and poor indeed is the small tradesman or clerk whose family does not obtain at least a taste of country joys. The schools are shut, the church is closed, courts adjourn; even the doctor finds it to his pecuniary interest as well as his physical well being to follow his truant patients. Philanthropy steps in and the children of the poor are sent to farms and sea-side homes by the thousand.

Every year witnesses an increase in this great exodus, until, on many a day of July and August especially, as the stranger wanders through the deserted streets, past battened doors and closed shutters, it seems as if some overwhelming epidemic had swept over our cities. Other countries present somewhat similar phenomena, but far less extensive and universal. Said a distinguished English lady—"What strikes me more than anything else is the great number you have of what we should call pretty, middle class country homes. We have nothing at all to correspond to them. When we leave London for the hot months, unless asked to the great houses for visits, we must go to the continent." Similar remarks are true of France and Germany. It would be interesting to trace the rise and progress of this social custom, its causes and its effects upon the intelligence, morals and health of the community. But such is not our present purpose.

In certain aspects of the case, we may divide these pilgrims into three varieties: 1. Fashionable folk and travellers. 2. Sportsmen. 3. Those in moderate circumstances who seek change and rest and recuperation in country homes. From another standpoint they may be classed as the sick and the well. Of the invalid and his interests we do not propose now to speak, nor of the fashionable or sporting classes, but rather of matters that concern the vast majority of healthy people of moderate means and needs. These we desire to aid in an intelligent search for restful and healthful summer homes. To those familiar with this subject it is clear that few of this sort of people possess the requisite sanitary knowledge to fit them

for such a function. Social influences, expense, accessibility, appetizing food, scenery, etc., form the chief and deciding factors in their selection. But, granting the importance of all these, it is a truism to insist that they should be subordinated to sanitary considerations. Refuge in the "bosom of nature" is poetic and attractive to one condemned to the more artificial life of the city. Deliverance from confusion and noise and deadly heat are eminently desirable for him and his family. But he should clearly understand and appreciate that in country life, as it exists, there are many and great dangers. To point these out in plain and simple words, as well as to suggest to those whose office and interest it is to supply the needs and meet the wishes of these people, what those needs and wishes are, are the objects of the writer.

There can be no question that, during three-fourths of the year, health and comfort are attainable in their highest degree in the better portions of our cities. Houses here are more perfectly constructed; their lighting, heat and ventilation are better. Greater care is bestowed upon an abundant supply of pure water. The best of food is afforded in greatest variety. Drainage is more effective than is usually possible in the country, while mental and moral pabulum are incomparably superior both in quantity and quality. But with the advent of hot weather, often early in June, certain injurious features of city life begin to be felt with great force. Chief among these is the absence of cool nights, and a consequent lack of refreshing sleep. The stones and brick of the walls and streets retain the heat absorbed during the day, and radiate it slowly through the night. This means a probable average of ten degrees difference in favor of the night temperature of the country even in the same locality, and this practically signifies to the citizen vital exhaustion, a continuance of which is apt to result in the peculiar diseases of summer. Other factors, especially impure air, might readily be named, but this is the important and decisive one; and therefore it is that a change from city to country life becomes, under these circumstances, desirable to all, and to the feeble and young absolutely essential. It is not unusual to hear this custom decried by thoughtless persons who esteem it the *summum bonum* of life to adopt what they deem good habits, and to pursue the same throughout every season and under all

circumstances. Changes, especially sudden and violent changes of all sorts, they deprecate and avoid as the most inimical and destructive of agents. They eat and drink and sleep and exercise by invariable rules—good rules often—and expect to reap the rewards of their virtuous self-denial in long, painless and happy lives. Such persons argue that their city homes, because most comfortable in some respects, are the best places in which to spend the summer as well as the winter. A little reflection should convince them of their error. Change, constant and ever recurring, is a prime necessity of life in both the animal and vegetable world. Uniformity, persistency, changelessness in environment presage and postulate death. Of course, it goes without saying that all life would equally be extinguished by too wide a swing of external forces. Life, on the average, is longest and best in a happy medium between death-dealing stagnation and volcanic explosion of natural forces. It is richest and fullest in the most fickle of climates. And thus, when the heat of our summers becomes fierce and continuous, a transition from the polluted air and burning streets to the pure fresh breezes and cooler nights afforded by the country districts brings rest, refreshment, recuperation. At least these are what they would bestow were life there always what it is fondly imagined to be. Alas! that by the ignorance or indifference of man, their “savor of life” is too often transformed into a “savor of death.”

What, then, are some of the prime qualities of a healthful summer residence? This is a very broad subject, and only glances at it can be taken here. In the first place, it should stand upon the right kind of soil, in a proper location, and not where mere convenience or roadways dictate. Soil is not simply earth. It is porous and contains air and water in varying amounts, both of which are liable to pollution. Take a pail of dry earth, saturate it with water, and you have in the bulk of the latter the quantity of air contained in the former. The dryer the soil the healthier it is as a building site. Consequently, sand or gravel or rock affords the best foundation for a house; nor should the sand be underlaid by impervious strata, such as “hard pan” or clay, near the surface, since this prevents the filtering away of the ground water. Low-lying meadow-lands bordering upon streams are also notoriously unfit

for building, for the same reasons and because these are the favorite haunts of malaria. The choicest locations lie on moderate slopes with all outbuildings geologically below the house. It is true that much can be done to obviate the natural results of ill-selected situations by such construction of the cellar floor and walls as will make them impervious to the ground air and water; but this expensive work is seldom or never lavished upon that class of residences. The cellar floor is of earth, its walls are laid in ordinary mortar, and both are easily penetrated by air and water. Indeed, the heating of the air in the house causes it to rise, and thus the ground air is virtually drawn up through it.

The soil and the cellar, then, are worthy of our first consideration in selecting a summer home. Something of the first may be inferred from the general location. More, by observing the surface of the cultivated fields near by. More, by the nature of the trees that grow in the woodlands of the vicinage. More, by the length of time rain-water remains upon the surface. More, still, by noting whether the inevitable well is shallow, and by inquiry as to whether it penetrates impervious strata. Mouldiness of the cellar and its contents, as well as of the walls of the lower floor will also speak volumes as to relative humidity. The cellar, too, should be well lighted and ventilated. That it should likewise be clean need not be asserted. Much more might be said upon this topic, and more exhaustive examinations of the soil are practicable; but such are rather adapted to treatises upon country architecture. Enough has been hinted to afford all that will be necessary if carefully and practically heeded. It is well next to observe whether the eaves of the house are properly supplied with troughs, so that rain-water does not flood its walls. Too often, when present, they are out of repair or choked with dead leaves, so as to be inefficient, or leaders and cisterns are conspicuously absent. Too great a collection of shrubbery and vines around or upon the walls of a house, as well as too many trees of heavy foliage are conducive to an excess of moisture, and should be avoided, especially by those inclined to rheumatic complaints. No country home should lack sound and effective blinds, which can be closed in the hotter days. Porches, too, should be roomy and plentiful. It seems trivial,

perhaps, but every home in city or country can and should be made proof against ordinary household vermin. Cats are usually relied upon to destroy rats and mice; but their nocturnal habits render them such a plague that a vigilant terrier is far preferable. Indeed, such a dog, with a more robust and good-natured assistant in the shape of a mastiff, forms a very desirable inhabitant of the farm-house in many ways. Properly-managed screens and blinds can also do much in mitigation of the plague of flies and mosquitoes, which in the aggregate destroy much rest. Improperly used they keep these insects in quite as much as they bar them out. Occasional spraying of the air of rooms with the oil of lavender, while agreeable to man, is vastly discouraging to these pests.

Next to the house that shelters one should carefully investigate the supply of drinking water. This is doubtless the most fertile source of disease existing in country life. Poetry has hung a wreath of imperishable beauty upon the old oaken bucket; but science looks askance at it, well knowing its usual deadly contents. The truth is that there is scarcely a farm well in existence the water from which, though to the eye and mouth it may seem pure and sweet, is fit to drink. And this in spite of the fact that the inhabitants may point with pride to their exuberant health. For the human system gradually becomes so accustomed to even virulent poisons by long habituation that they cease to produce deleterious effects, while they are certain to manifest their destructive influence upon those who are strange to them. The consumers of tobacco, of opium and of arsenic afford familiar examples of this scientific truth. It seems highly probable that the germs of typhoid fever, that plague of country life, obtain access into the human body through drinking water. In the numerous instances where this disease has been traced to the milk supply it has uniformly been proven that the cans had been washed in or the milk adulterated with polluted water. That such is the unanimous opinion of the medical profession is evidenced by the universal prescription of a milk diet through the entire course of this fever. How water becomes impregnated with this germ is as yet not demonstrated; but certainly the well water of the ordinary country-house has plenty of sources of impurity. Wells, for our purposes, may be divided into those which are supplied

by surface drainage and those which obtain their water from below impervious strata. The former are most liable to pollution; but even the latter are often fouled by infected ground-water, since their walls are entirely pervious, and the surface-water, holding in solution all the impurities it has met with since it fell as rain, leaks into them. Only to deeply-driven wells, which are rarely found, are these remarks inapplicable. To one familiar with the relative situations of the barn-yard, the out-buildings and the drains of the average country-house the assertion that no ordinary well-water is an entirely safe beverage will not appear extravagant. It can be made so in every instance, however, by boiling, always provided that it is not again befouled by impure ice. Of this latter substance the farmer's sole source is too often some shallow pond or stream which is heavily charged with organic matter in a state of decay, so that it is safer to cool the boiled water in bottles into which ice does not enter. The flat taste of such water may be obviated by a partial filling of the bottles and by shaking them, thus restoring the air which was driven off by boiling. If instructed adults alone were concerned, this precaution might be sufficient; but in view of the fact that children and other irresponsible persons may be tempted to overstep the bounds of prudence, it is desirable and easy to make such chemical tests as will render harm less likely.

The following are in common use and are reliable:

**TEST 1.**—Obtain at the druggist's, five grains of the nitrate of silver, and dissolve them in an ounce of distilled water, in a dark colored bottle; of this, add a teaspoonful to a glass of the suspected water. If a white cloud forms therein, it demonstrates the presence of chlorides. In case salt has been used near the well, or if the location is near the sea-coast, this test is not to be depended upon. Otherwise it renders it certain that the water is defiled by the proximity of some polluted source.

**TEST 2.**—Obtain a solution of the permanganate of potash—five grains to the ounce of water. Add to the suspected sample enough of this to give it a pinkish color. If this disappears within a few hours, and the water becomes colorless, organic matter is present to a dangerous extent.

**TEST 3.**—Warm some of the water in a bottle. To this add a piece of caustic potash as large as a large pea. After shaking

the bottle until this is dissolved, smell of its contents. If an offensive odor is perceived, the water is too impure for drinking purposes.

Of course, other and more perfect analyses are possible, but these are within the reach and skill of any one. Ice, when melted, may also be thus tested efficiently. If the supply of drinking water comes from clean and well kept springs, no uneasiness need be felt. Every country house should be thus supplied, if possible. The nature of the pipes through which it flows, so long as they are sound and whole, is a matter of indifference.

The receptacles for excrementitious substances, common and almost universal in villages as well as farming districts, it is impossible to characterize too severely. They are barbarous, indecent, outrageously offensive, and most productive of disease. And the worst of it is that the existing state of affairs is born of sheer laziness. It is so readily and cheaply avoidable, and information on this sanitary matter is so widespread that only motives of such a sort can permit the continuance of customs so abhorrent. A shallow zinc-lined receptacle so arranged as to be readily drawn away by horse-power, together with a barrel of dry earth in each out-house would render the whole so inoffensive and innocuous, and at the same time afford such a valuable fertilizer that it would appear that even the decency of a cat might be appealed to. And yet reform in this particular lingers. Disease and death have no more fertile sources. Almost as criminal is the slovenly way in which the slops of the kitchen and house are thrown out upon the earth near the house, left to soak into the ground and befoul its water and the air which the heated house sucks up through the cellar, when proper drains and cesspools might be effective and harmless.

Still another source of disease to the unwary is the wider swing of the diurnal temperature in the country. If the brick and stone of the city part with their heat more slowly, and thus maintain a higher temperature at night, they also acquire heat more slowly, so that the difference between noon and night in the country is widened at both extremes. The newcomer from the heated city, thoughtless of all but his comfort, is too apt to imprudently expose himself after the sun goes down. The sud-

den and more complete cooling of the air causes it to exude moisture and produce dew, and to this, also, he is unaccustomed. And so he sits upon the lawn or piazza until chilliness overtakes him. Daily recurrence of such experiences soon results in influenza or deranged intestinal action, or, if mingled with some even mild malarial infection, precipitates an intermittent fever. The moral is plain. Additional clothing at sundown is necessary. Breathing the night air may be harmful to those of delicate lungs, but much more important is this evening chilling of the body surface. I omit reference to the disposal of garbage as, in farming districts, it is fed to the swine.

Nor, except in the rare instances where water closets are in use, is the question of sewage of such manifest importance as it otherwise would be. Of course, a suitable drain and cesspool are requisite to the proper disposal of the slop-water from the various parts of the house. But even common sense on the part of host and guest is a sufficient guide in regard to this important matter.

Such are some of the more prominent dangers to be encountered in ordinary country life. Most of them may be avoided or prevented, and they will be when intelligent demand insists upon reform. Every day it becomes more manifest that city boarders are and are to be the chief source of the farmer's income at least in New England and the Middle States, and sanitary education of both host and guest will be of equal and mutual benefit. If this is true, there would seem to be good reasons why the proprietors of country homes should not only reform in the sanitary matters above indicated, but should also study and endeavor to supply the peculiar wants and wishes of their patrons. This is remunerative in all varieties of business, and this peculiar example is not an exception. Only crude and vague ideas upon this subject are prevalent, however, and, so, perhaps, it may not be amiss, in concluding this sketch, to enumerate some of the chief features of an attractive and healthful summer home in the "real country," as the phrase goes.

Since rest is one of the main objects desired, and to that end sound sleep is essential, it follows that good beds are a prime prerequisite. These should consist of the best woven

wire covered by a thick mattress of curled hair. It is true that these are expensive in first cost, but in the end they are not. The same is true of the best feather pillows. A few may prefer hair. The fields and woods are full of sweet scented shrubs wherewith dainty New England matrons are wont to perfume their bed clothing—a most inexpensive luxury. The other furniture of the bed room should include bedsteads of enameled iron, a sufficiency of comfortable chairs, a decent reading lamp, an honest table, a big can of fresh water, a bathing tub, and an abundance of towels. None of these need be expensive but they should be solidly made. The floors of halls and bed-chambers should be painted, and their walls and ceilings kalsomined. Halls and stair-cases should be covered by rubber cloth which is both noiseless and cleanly. Rugs made of the remnants of Brussels carpet or strips of carpet should furnish those parts of the floor of chambers where footfalls are most likely to produce noise.

Next in importance comes food. The lack of good healthful and tasteful cookery, in suitable variety, is lamentably common in the country, and in no respect is reform more necessary. Meats are overdone and vegetables underdone almost universally, while good, wholesome bread and pastry are almost unheard of. Few summer boarders would complain if beef and veal and mutton were entirely banished from the table. They are so uniformly bad in the country, that, with the exception of corned beef and its derivatives and an occasional well-made stew, they should be excluded altogether. Good, well-cured ham, dried beef, bacon, fowl of all varieties and fresh water fish are all the meats desirable. Since the establishment of hatcheries it is amazing that clubs are not formed among country folk to stock their streams and lakes with desirable fish which would afford both sport and most acceptable food. An abundance of fresh eggs furnishes many tasteful dishes, while plenty of milk and cream and sweet, fresh butter are always in demand.

Early attention and even hot-bed cultivation ought to furnish the table with fresh vegetables. The difference between freshly picked garden produce, and that obtainable in cities needs only to be once tasted to be forever remembered, and yet not one farm in twenty has a kitchen garden worthy of the name. The

wild and garden fruits are seldom served, when an abundance of them would be inexpensive and most acceptable. Nearly every farm has pastures or clearings where, even if permitted, blackberries, and raspberries and whortleberries would thrive, while currants and gooseberries need almost no cultivation. Harvest apples are a great and easily attainable luxury. While upon this topic it may be mentioned that a half acre of flowers would furnish a wonderful attraction and find plenty of lovers and caretakers among the guests.

By providing suitable barn amusements for children, the rainy days would be greatly lightened of their burden. No words nor colors can adequately depict the delights possible here. If the country house is situated upon a lake or stream of sufficient size, a fleet of good, safe, flat-bottomed boats, equipped for feminine and childish hands, should be provided. For very little in country life can compare with the restful charms of a day on the shores of our inland waters or excursions into the forests that fringe them. Rough shelter houses or tents and swings in groves where picnics, and play are afforded to children of larger and smaller growth would be of no mean value.

But why prolong the list? Who that has been privileged to spend his youth in the fields and woods needs further disquisition? Hard, indeed, the lot of man or woman whose life memories are forever bounded by the streets of a city. Beyond lies the country—a fairy-land—pure and tranquil, remembered well through all the vicissitudes of later years. In this precarious world, it may not always afford happiness, but to every weary toiler it might bring rest and peace and health.

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WHOOPING-COUGH AND CEREBRAL PARALYSIS.—Dr. Neurath, of Vienna, recently reported three cases of cerebral paralysis associated with whooping-cough. In one case there was a cerebral hemiplegia, spastic paralysis of the upper arm, augmented reflexes in the leg of the same side; in a second case the same symptoms and besides attacks when the child would lie almost lifeless with extensive paresis, loss of speech and convulsions. In the third child, where complicated with a bronchiectasia, the paralysis also was associated with facial paralysis, increased reflexes and increased irritability of the left upper, lower and upper extremities. All three cases recovered more or less completely, only in the last case there was a systolic cardiac murmur and a perceptible accentuation of the second pulmonary sounds. He thinks that the complication was dependent upon a rupture of the walls of a blood vessel, cerebral hemorrhage, though in his third case cerebral embolism was more probable, or possibly, encephalitis.—*Muenchener Medizinische Wochenschrift*, No. 43.

## CORRESPONDENCE.

## TWEEDLE-DaM, OR TWEEDLE-DeE.

IN spite of the flavor of profanity (accidental, and unintentional), given to the old saw by the above change, we have ventured to use it in its new dress as a caption in order to indicate our estimation of the value of the investigations and discussions lately revived as to the way in which Hahnemann wrote the motto of our school, whether *Similia Similibus Curantur* or *Curentur*. We think it is altogether a question of moods, grammatical and otherwise.

We know that the interest felt in the question must differ somewhat both in degree and kind from that felt in collating and comparing the ancient MSS. of books to which the idea of plenary inspiration is still attached. In this latter case the discovery of the Codex Sinaiticus by a Tischendorf, in a convent on Mt. Sinai becomes a momentous event to the whole religious world, for upon it may depend the truth of doctrines accepted throughout Christendom as of divine origin. With the resuscitation of the passage in which Hahnemann employed the word in question, by our industrious bibliophile, Bradford,\* it is far otherwise. Here the importance of a settlement of the question is of an altogether personal nature, interesting of course as showing *perhaps* Hahnemann's views as to the universality of its application, but not of necessity binding upon his successors.

Knowing that to Hahnemann the Latin was as familiar as his native tongue, we would naturally expect that where in the course of an essay he "dropped into Latin," the form of the word used would depend upon the thought dominating the connection in which it occurred. Hence we would find the subjunctive or the indicative, according to the requirements of the context. To our, perhaps benighted, mind this common-sense view of the question causes much of even the archaic interest to fall away, and it ultimately becomes a matter of indifference

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\* *The Medical Visitor*, March, 1893.

whether he used an *a*, or an *e*, since at any rate he was not the first one to employ the sentence. In the Introduction to the *Organon*, the Similia Similibus Curentur is in evident opposition to the preceding Contraria Contrariis Curentur, which he calls a "rule" (*Regel*) of practice, the following of which results only in palliation.

As to the form to be adopted on a monument, or as a motto of our school, that should be decided upon other grounds, although the simple quotation of Hahnemann's own words would be likely to meet with most favor, or least opposition.

We have a sort of feeling, growing on us with age, that our time and energy in this life are too limited to waste much of either in deciding between Tweedle-dam, and Tweedle-dee.

Wm. H. BIGLER, M.D.

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**SARCOMA OF THE THORACIC CAVITY.**—Dr. H. Kohn recently observed a man of thirty-six years who suddenly felt ill. He complained of pains in the chest and attacks of paroxysmal cough, with slight expectoration. Fifteen days afterwards his condition became aggravated, and he had an attack of hemoptysis. On examination, an area of dulness was detected at the upper portion of the left lung, where no respiratory sound was audible. An exploratory puncture posteriorly gave issue to a limpid fluid, and a second, a little lower, to a reddish liquid which contained pneumococci. A chronic inflammation of the lung, with an encapsulated pleuritic exudate which would probably become purulent, was diagnosed. Indeed, in fifteen days an empyema was seen to follow, but, on operating, only a very slight quantity of pus was evacuated. A short time after the left side became more convex anteriorly, the subclavicular glands swelled and soon the patient died.

The necropsy revealed an enormous tumor, involving the lungs and bronchi, which the microscope showed to be an alveolar sarcoma. No cancer cells were to be made out in the sputa, possibly because the lung did not functionate. The writer has also seen a case which was absolutely the reverse of this. In a patient where he had diagnosticated a tumor of the lung or mediastinum, at the post-mortem only a chronic inflammation of the lung was found. This patient presented the same symptoms as the first, besides having a paralysis of the vocal cords.—*La Semaine Médicale*, No. 59, 1895.

**HEMIPLEGIA IN TUBERCULOUS MENINGITIS IN CHILDREN.**—Dr. Zoppert mentions hemiplegia as an important though, he admits, an infrequent symptom of tuberculous meningitis. He here means neither the paralytic phenomena of the last stage nor that due to solitary tubercle, but those cases that present a definite and established hemiplegia during the stage of development, and which form one of the principal symptoms of the clinical picture. At times a one-sided paralysis may open the scene and remain uncomplicated, or be accompanied by hemilateral convulsions or aphasia, or, indeed, the beginning may be apoplectiform. There are cases where no anatomical substratum is to be detected post-mortem to explain the paralysis. Still, the accumulation of exudates upon the convexity of a hemisphere is the most common cause of the disturbance; the exudate need not by any means be abundant. The other causes are softening and inflammatory foci in the capsular region or of one hemisphere and formation of exudates upon a cerebral peduncle. Clinically, it is at present impossible to differentiate the seat of the lesion.—*Lo Sperimentale*, No. 29, 1895.

## EDITORIAL.

## SIMILIA SIMILIBUS CURANTUR.

WHEN the members of the Hahnemann Monument Committee were about deciding upon the inscriptions for the Monument they found themselves face to face with a question which while not new will require a nicety of decision to give satisfaction to all concerned, if that is possible. The problem arises as to what is the correct rendering of the so-called, Hahnemann's formula as applied to homœopathy; which, by the way, did not originate with Hahnemann, as some seem inclined to believe. On the shelves of the Library of the Hahnemann Medical College of Philadelphia is a work on *Reflections upon Catholicicons, or Universal Medicines*. By Thomas Knight, M.D. Published in London in 1749, or six years before the birth of Hahnemann. On page 62 of which is found " *Similia Similibus Quæque Curantur* is not so sure a maxim as its opposite, *Contraria Contrariis Curantur!*" Demonstrating clearly that these are old medical maxims probably of centuries standing.

The English-speaking portion of the profession has long been familiar with the sturdy classic indicative form, " *Similia Similibus Curantur*," which states a positive fact that " likes are cured by likes." We are told that it was originally used in this connection by Dr. Black, of London, in the first number of the *British Medical Journal of Homœopathy*,\* in 1843. It is said that exception was taken to its use by Hahnemann, who modestly rendered it conditionally in the subjunctive mood, " *Similia Similibus Curentur*," which is literally " likes may be cured by likes." This latter was suitable and appropriate in the early days of trial and investigation, and was worthy of the scholarly, masterful mind of the most accomplished and scientific physician of his age. Nothing could have more moderately stated his proposition, but homœopathy has passed the experimental stage and, speaking from the standpoint of a

On examining this number which was published in January, 1843, by J. J. Drysdale, J. R. Russell and Francis Black, editors, the "e" is found to be invariably used.

proper recognition of the scope and limitations of the law of cure, it has been unequivocally demonstrated.

All of us are convinced "likes may be cured by likes" and we are prepared to go a step farther and assert that "likes are cured by likes." Beyond this we come to cross-roads, for some claim a universal application of this law, while others maintain and insist upon clean and clear cut limitations.

At this centennial epoch of homœopathy, with the existing desire to improve homœopathic therapeutics, the *Materia Medica Conference* to be held at Detroit in June next has appropriately decided to examine the status of homœopathy by discussing, among other things, the topic: "Has the law of the similars ever been unequivocally demonstrated by the deductions from general practice, etc.?" Such searching fundamental inquiry is right and it will be found that such reviews are strengthening to the scientific position of homœopathy.

When we come to stating to the world our working formula, we should utter it with no uncertain ring. This is the place for honest dogmatism. The question of the "may be" or the "are" is simply the revival of an old one and, judged by the law of the survival of the fittest, the "are" should win. If, however, the committee wishes to place upon the monument the form of this ancient maxim (as old as Hippocrates himself) which Hahnemann used, their course is clear for Hahnemann invariably used *currentur*—the subjunctive form—the "may be."

We do not presume to make suggestions in this matter; but we venture to express the hope that the way will open up for the committee to inscribe in bold and striking letters upon the memorial which our gratitude suggests to perpetuate the name and work of Hahnemann as a heritage to all ages, the regular classic form "*Similia Similibus Curantur.*"

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#### RECIPROCITY.

WE took occasion last year to urge the establishment of the principle of reciprocity between the examining boards and medical councils of the various states, if the whole matter of state examination was to receive a fair trial, and not be weighted with burdens too grievous to be borne. The matter has again been brought to our notice by the statement in the

Fifth Annual Report of the State Board of Medical Examiners of New Jersey, that the Regents of the University of New York refuse to accept its certificates in lieu of further examination. This is done, the report states, in spite of the fact that the medical requirements and examinations of the New Jersey board are practically acknowledged to be higher, and its academic requirements as high as those in New York.

On the other hand the medical council of Pennsylvania has decided to accept the certificates of New Jersey, while this latter has endorsed 16 certificates issued by the Regents of New York, and 9 issued by the council of Pennsylvania, refusing endorsement, however, to certificates from other states whose respective standards both in academic and medical requirements were found to be lower than its own.

The hardships entailed upon the physician by the necessity of re-examination when removing from one state to another, while perhaps intended, or at least, viewed with favor by those who see in this movement a means of protecting the resident physician from undue competition, should certainly not be allowed by those who hold logically to the avowed purpose of the boards, viz.: to protect the public from incompetent practitioners.

A standard of academic requirements can only have reference to the fitness of an individual to undertake the study of medicine, provided the standard of medical requirements is placed sufficiently high, and is therefore illogical in connection with judging of his fitness to practice medicine. We go still farther and maintain that the demand that the knowledge possessed should have been acquired in a medical college is also illogical and foreign to the professed purpose of these state examinations. If the diplomas of the various colleges are to have no weight or worth, why require their possession as a prerequisite to examinations by state boards? These latter could and should be made sufficiently rigid and exhaustive to test the possession by the applicant of such knowledge of the science and art of medicine as to make him a worthy practitioner, regardless of the place where, or of the means by which he may have acquired this knowledge. Its possession is the only question with which the state boards have any rightful concern.

So long as the present system is in vogue, let there be a uni-

form high standard of medical attainments only—much higher than at present demanded—established by an Interstate Board, composed of representatives from the various state boards, and then let a certificate issued in one state be recognized in all others. This seems to be the only rational solution of the question as at present understood, although our own view remains unchanged that justice to the individual and to the colleges demands that the philanthropic, public-protecting Cerberus should guard the entrance of the colleges and not be placed at the exit.

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#### THE CENTENNIAL OF HOMŒOPATHY.

THE centennial of the promulgation of homœopathy is at hand. Hahnemann, in 1796, published in Hufeland's *Journal* his first communication to the world of his new discovery in medicine, in an "Essay on a New Principle for Ascertaining the Curative Powers of Drugs." This was the first note of the reformation of medicine which has ever since steadily been pressing forwards with increasing strides, over the civilized world and stamping a lasting impression upon the therapeutic work of all schools of medicine. The universal recognition that the centennial of homœopathy should not be permitted to pass without a fitting commemoration of the great event of 1796, leads us to once again call attention to that most excellent and comprehensive report of Dr. Dudley as chairman of the American Institute Committee on the Centennial of Homœopathy which awakened so great an interest and aroused the enthusiasm of the members present. We can only refer here to its more salient features; it will be found in full on page 96 of the "News" in the July, 1895, HAHNEMANNIAN. The report divided the subject into two questions.

First, should the Institute take any action in view of the approaching Centennial of Homœopathy? And if so, then second, what action should be taken?

In seeking a solution of the first question, we must bear in mind that the prominent anniversaries of any great enterprise connected with human progress and welfare, like that of homœopathic reform in medicine, furnishes occasions and opportunities for promoting such movements that do not present themselves under ordinary conditions and circumstances. In-

deed, the first centennial of homœopathy occurring, as it will, but once in the world's history, may be employed to advantage by enabling us to impress the public mind with the stability, and, inferentially, the truth of its doctrines, and the efficiency of its practice. It will also give large opportunities for attracting to the Institute, as well as to other societies, a stronger interest on the part of the profession, and most important, perhaps, of all, it can be made to secure for our hospitals and other benevolent and educational institutions a higher appreciation and a more general moral and material support. For these reasons the committee recommended that the Institute should provide some suitable celebration of the anniversary.

The American Institute of Homœopathy could hardly feel much enthusiasm in any celebration which had for its object the mere glorification of a man, even though that man were Hahnemann. Still less, probably, would she care to employ such an occasion for the purpose of paying empty compliments to her members, living or dead. Least of all, could the Institute have any patience with the thought of a mere jubilant "Hurrah," whose influence should end with the last splutter of its expiring fireworks. For any such celebration it has neither the time, the talent, nor the inclination.

In the commemoration of the event of 1796, we should have before us, as its principal object, the promotion of the cause which was then inaugurated. In other words, the celebration should be in strict harmony with the "object" for which the Institute was organized, as expressed in the opening Article of the Constitution. In carrying out these objects the celebration is to be directed to the following specific purposes, namely:

- (a) To pay honor to the character, genius, and labors of Hahnemann, and to the worth of his discovery.
- (b) To establish memorials of the man and of his discovery.
- (c) To re-examine the law of similars in the light of modern knowledge and science.
- (d) To employ the occasion as a means and opportunity for further extending the knowledge and influence of homœopathy and for imparting a new impetus to its development.

The central thought of the celebration is to be the discovery promulgated in 1796—the law of similars. Public and professional attention should be drawn as strongly as possible to this particular subject as the distinctive and essential "truth" of homœopathy, while other truths taught by Hahnemann and held by his followers should, for the time being, occupy a secondary place. This sharp distinction should be made for the purpose of forcing public and professional recognition of the real and essential question at issue between the two methods of medical practice.

It was decided that the celebration should not be restricted to the national society, but in certain ways should be co-extensive with our country and its influence maintained throughout the centennial year.

The Centennial of Homœopathy will thus be celebrated by the American Institute, first by a *Materia Medica Conference*, held in Detroit in June, 1896. Second, by a celebration of a public character, to be held at Detroit, in connection with the meeting of the American Institute, at which an address on the character, discoveries and labors of Hahnemann will be delivered by President Dudley—this taking the place of the usual presidential address, and to be known as “The Hahnemann Oration.” The celebration is also to include three centennial addresses on the “Law of Similars,” to be delivered before the Institute in general session, the addresses being as follows:

1. “The Logical Basis of the Law of Similars. Does it Commend Itself to our Reason?” By Dr. Richard N. Foster, Chicago.

2. “The Experimental Demonstration of the Law of Similars. Can its Existence and Operation be Proved?” By Dr. M. W. Van Denburg, Fort Edward, N. Y.

3. “The Clinical Efficacy and Superiority of the Law of Similars. Is it a Reliable Guide in the Practice of Medicine?” By Dr. John Preston Sutherland, Boston.

The selection of the essayists for the consideration of these vital subjects will be received with satisfaction and commendation by the profession, and they will acquit themselves in keeping with the importance of the occasion.

Homœopathy expects every man and woman in the profession to do their full duty in the year 1896, and we particularly desire to call the attention of every homœopathic physician, and especially of those in positions of responsibility, to the recommendations of the committee which bear directly upon State, county and local interests; and we further wish to impress upon *all* the necessity of taking immediate advantage of the opportunity that is now presented.

*First.*—The committee recommends that each State and local society provide a celebration of its own of such a character as to draw public attention to the Centennial of Homœopathy, and the important results of Hahnemann's law of cure.

*Second.*—That the friends of each homœopathic hospital in the United States should, during the year, endow at least one bed in perpetuity, to be so designated and inscribed as to constitute a permanent memorial of the centennial and of the event which it celebrates.

*Third.*—That each city and large town not already provided with a homœopathic hospital, should, during the year, inaugurate a movement to secure such an institution.

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#### THE ST. LUKE'S HOSPITAL.

In line with the recommendation of the Committee of the American Institute on the Centennial of Homœopathy, the St. Luke's Homœopathic Hospital was started in the city of Philadelphia on January 9, 1896. The movement was launched with the idea of supplying an apparent need, commencing in a modest way, with as perfect an organization as possible, and governed by the spirit of no antagonism with institutions of similar character. The present building is situated on Broad Street, about three miles north of the well-established Hahnemann Hospital.

On our news pages will be found an account of the hospital building and the list of the officials and staff of the hospital. From the well-known names thereon, it will be seen that personnel of the movement is trained and capable of taking excellent care at full pressure of a hospital of upwards of two hundred beds. The operative work of the first few weeks, considering the newness and limited capacity of the hospital, has been phenomenal. The trustees report the work done in January and February as follows: Patients admitted in January, 15; in February, 19; total, 34. Discharged, 25. In hospital, March 1, 9. Number of major operations, 25. Out-patients registered at dispensary, January, 116; February, 117; total, 233. Visits, January, 314; February, 457; total, 771. Prescriptions, January, 350; February, 340; total, 690. The hospital is in charge of twenty-five trustees and thirty-five physicians, and, while limited in its work by its resources, the trustees think the work accomplished shows that it has a wide field for

usefulness, and they trust that long before the Bi-centennial of Homœopathy it will have developed into an institution of magnificent proportions.

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#### THE PENNSYLVANIA STATE MEDICAL EXAMINERS.

THE members of the profession living in the western part of Pennsylvania have been urgently advocating, that an examination for the granting of medical licenses to practice in Pennsylvania be held in Pittsburg at the same time the examination is held in Philadelphia, on the plea of economy and convenience for those desiring to take such an examination. This request seems legitimate, and we know of no worthy reason why it should not be so held. Drs. Cooper, of Allegheny City, and Cranch, of Erie, the western members of the Medical Examiners' Board, for the Homœopathic school, are fully competent to hold such an examination for the board, and it would certainly be more convenient for them to go to Pittsburg rather than to Philadelphia. We hope that the suggestion of dual places of examination will be considered and given a fair trial.

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**Poisoning by the External Use of the Subnitrate of Bismuth.**—Dr. Gaucher, of Paris, recently reported before the Society of the Hospitals of Paris four cases where toxic symptoms had been observed after the use of the subnitrate of bismuth externally. In the first three cases the patients were suffering from crural ulcers, and the fourth, a woman, had been burned on various parts of her body. These patients had been treated each day with the subnitrate locally as a dressing. The first symptom of poisoning was a line along the edge of the gums similar to that of lead poisoning but still more slate-colored. This was accompanied by patches, as if tattooed, on the cheeks, and, finally, an actual stomatitis, followed by secondary infection, appeared. Discontinuance of the use of the drug caused the symptoms immediately to disappear. The subnitrate was found by analysis to be free from all impurities, as lead or arsenic. In the succeeding discussion Prof. Hayem stated that he had used large doses of the drug by the mouth, and has never observed any disagreeable after-effects. Probably the gastric juice modifies it.—*La Semaine Médicale*, No. 60. [Prof. Kobert, *Lehrbuch der Intoxikationen*, Stuttgart, 1893, p 412, claims that both the internal as well as the external use of this drug will give rise to poisoning. He cites a number of writers, among whom are several surgeons, who have observed toxic symptoms after its use as a surgical dressing. Taken internally, the greater portion passes off unabsorbed, on account of its insolubility, or it is transformed, in the intestine, into the sulphate of bismuth. The remedy appears to be chiefly, though not wholly excreted by the large intestine, which is colored a deep black and filled with numerous necrotic patches. He also mentions a form of stomatitis which resembles that of mercury, with swelling of the gums, tongue, loosening of the teeth, a black line along the edge of the gums and ulceration of the mucous membrane of the mouth. Intestinal catarrh and nephritis have also been noticed.—EDS.]

## GLEANINGS.

### GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D., AND FRANK H. PRITCHARD, M.D.

**DIAGNOSIS OF SALIVARY STONES.**—Dr. Lindemann relates an interesting case of a salivary stone which he observed in a woman of fifty years who thought the neoplasm to be of a malignant nature. The tongue, especially in its left half, was enlarged, presented deep marks of the teeth and oedematous margins; the left sub-lingual salivary gland was also swollen and its surface was of a dark red color and covered with a network of sinuous veins. To the touch the tumor was decidedly hard and cartilaginous. The lymphatic glands of the chin were also quite swollen, the surrounding cellular tissue infiltrated and the skin reddened. The patient also complained of headache, sleeplessness, thirst, loss of appetite and great weakness. No elevation of temperature. The growth had gradually developed during the past six to eight months. A pseudo-neoplasm was suspected and a puncture with a hypodermic needle confirmed the diagnosis. An incision exposed a salivary stone, one cm. in thickness and three in length; the concomitant symptoms soon disappeared. The stone was unquestionably due to a deposit of lime-salt from the saliva which element is present in a large quantity, in the saliva of certain subjects.—*Deutsche Medicinische Wochenschrift*, No. 41.

**SALT WATER SOLUTION IN DIPHTHERITIC PARALYSIS OF THE SOFT PALATE.**—Dr. Ziem claims to have astonishing results in diphtheritic paralysis of the soft palate in several cases from irrigation of the nose with a solution of common salt and water; he thinks that it is possible to prevent extent of the affection to the pharynx and larynx. The injections should not be left to the patient's friends to carry out but be seen to by the physician himself and with a care that the fluid does not penetrate into the respiratory passages.—*Hospitals Tidende*, No. 49.

**IDIOPATHIC PERNICIOUS ANÆMIA ASSOCIATED WITH ARSENICAL PARALYSIS.**—Dr. Barrs reports the case of a man who for about a year presented signs of pernicious anæmia, for which he received Fowler's solution, beginning with 10 drops a day, which dose was gradually increased to 75 in the day. It was impossible to increase the dose for fear of poisoning; yet no improvement was noticed, but, instead, an actual aggravation. After a month of treatment complete arsenical paralysis of the lower extremities set in, with abolition of the patellar reflexes and pigmentation of the skin, especially of the hands and feet. The arsenic was suspended and bone marrow administered instead with the result that in a week the number of red blood corpuscles had doubled. The remedy was continued, the paralysis disappeared, and the disease was cured.—*Rivista Clinica E Terapeutica*, No. 9.

**HEART DISEASES OCCURRING DURING THE ESTABLISHING OF THE MENSES—THE MENARCHE.**—Prof. E. H. Kisch calls attention to three morbid states of the heart which are noticed during the menarche, as he calls it. The word is suggested by him as a corresponding one to menopause—menarche (menses, beginning).

The first condition is a nervous palpitation, with paroxysmal tachycardia, which is noticed in girls otherwise healthy, but which sets in before the appearance of the first menses and vanishes some time after their establishment. The digestion may also suffer in sympathy; the appetite is decreased, digestion retarded, the stool slightly constipated and at times there is nausea without apparent cause. At times the nervous system may be simultaneously affected; the girl loses her cheerful and joyous manner, becomes quiet, introspective, with no desire to learn

or exert herself. She easily becomes angry or irritable, sleeps badly, and thinks that she has a serious heart affection which threatens her existence.

The second condition is observed in chlorotic girls whose periods are strikingly delayed, even not appearing at the eighteenth, nineteenth or twentieth year. The external genitals appear well developed, or they may be still undeveloped; the mammae are very small, the pubes but little hirsute, etc.; or the menses are irregular, or if once appearing do not return for months or are very scanty and pale. In some cases the menstruation is very profuse and irregular and too long-lasting. In these subjects the cardiac affection occupies the foreground, so that organic heart disease is at once thought of. Frequent and violent palpitation is the most prominent symptom, with beating in the carotids, dyspnoea and anxiety on continuous movement or even but little excitement. The heart is not found enlarged, the sounds are clear, though there are frequent systolic mitral murmurs or even murmurs at other valves. In the jugular the bruit de diable is audible. The pulse is accelerated at times irregular and easily compressible. The skin of such a patient is very pale, whitish yellow the visible mucous membranes are very pallid, and the haemoglobin is decidedly reduced, the erythrocytes decreased in number, and there is a constant sense of fatigue and a series of changing nervous symptoms—in short the characteristics of chlorosis, though at times it may be met with under the anaemic form of general lipomatosis. In several of these patients acne vulgaris associated with ordinary comedones was noticed, and also profuse local sweating on the palmar surface of the hands or the soles of the feet with a bluish color of the nose and ears.

A third form of disease here remarked is a cardiac hypertrophy which develops during the menarche, and is dependent upon the changes in the circulation; it is also favored by rapid growth just before the appearance of the periods. These patients are neither anaemic nor nervous, but are strikingly slim and lank, and will be found "to have shot up" during the past year. They complain of violent palpitation, a feeling of fulness in the chest, dyspnoea on rapid movement. Objectively, the heart is discovered to be enlarged, especially in length; the radial pulse is abnormally strong and resistant, the heart sounds are augmented and the apex beat heaving and distinct. These patients suffer from an actual hypertrophy of the heart. They are not usually from the working classes, so that it is not due to overwork, but to the extra demands made upon the heart from rapid growth and the sexual development, both pelvic and mammary.—*Be liner Klinische Wochenschrift*, No. 3.

**TUMOR OF THE MED'ASTINUM.**—Dr O. Thiele was consulted by a young woman who complained of a heaviness of her head and a spasmodyc cough, without expectoration. Later, she was also a sufferer from increasing dyspnoea and cyanosis of the face. Examination of her chest revealed anteriorly an area of dulness which extended from her sternum to the right and the left as far as the axillary line. Within this zone no respiratory murmur was audible and the heart-sounds were heard as though through a layer of cotton. The larynx and trachea were apparently normal. A tumor of the mediastinum was diagnosed, which, from her age and the rapidity of its evolution, was probably a lympho-sarcoma. The necropsy confirmed this wholly.—*La Semaine Médicale*, No. 59.

**EXTRA-GENITAL CHANCRE.**—Drs. Krzyształowicz and Mayzel, from the Warsaw clinic for venereal diseases, since 1890 report that out of 74 cases of chancre, 73 were situated on other portions of the body than the genitals. They were observed on the lips, scrotum, breast, the tonsils most frequently, while the remainder were scattered over the anal folds, thighs, etc. As to their appearance and course, they did not differ from those of the genital organs. The general signs of precocious syphilis are already observed after cicatrization of the chancre; the more severe cutaneous eruptions were relatively frequently noticed, and particularly in women, where syphilis usually pursues a more benign course than in men. The writers hold to the view of Krefting, that extra-genital syphilis is liable to give rise to more severe forms than that acquired by coitus. One curious case is reported where a servant girl presented a chancre of a labium majus with an intact hymen. The ulcer had been produced by using, after bathing, the towel of a female companion who had the disease. This patient communicated the disease to a stewardess of the hospital through the common use of a table-dish; the latter had a lesion on her upper lip.—*Przegląd Chirurgiczny*, tom. ii., zeszyt. iv. [The greater gravity of extra-genital syphilis is denied by Fournier. Pronostic de la syphilis issue de chancres extra-génitaux.—*La Semaine Médicale*, No. 60.—Ends.]

## GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D. AND H. L. NORTHRUP, M.D.

**COCAINE IN SURGERY.**—Gabryszewski, an assistant of Rydygier, is an enthusiastic advocate of cocaine, which, if rightly employed, never fails and is also totally devoid of danger. A good preparation is of great importance. He applies it to mucous membranes with a brush; in 10-20 per cent. alcoholic solutions, while subcutaneously and parenchymatously he uses a 3 per cent. watery solution. The anæsthetic fields must be so grouped that the whole area is rendered devoid of sensibility. He uses short and strong needles, so that injection into firm tissues or even softened bone is possible. Capital operations contraindicate the anæsthetic. He warns against injecting it into abscess cavities, as by increase of tension the pain may be increased. The danger of toxic symptoms is slight if the dose be carefully watched. In tired, sleepy, nervous, weakly, anæmic and cardiac patients, for the sake of caution, as well as in operations on places where a reaction is prompt—for example, extraction of the wisdom teeth—he advises allowing a few minutes to pass before making a second injection, as the symptoms of poisoning usually rapidly appear. A horizontal position is to be advised in those liable to faint. He has found the drug to anaesthetize not only the terminal extremities, but also the trunks of the nerves.—*Centralblatt für Chirurgie*.

**SERVICEABILITY OF LIMBS AFTER SIMPLE FRACTURES.**—Haenel has collected four hundred cases of simple fractures observed in Saxony, with regard to the serviceability of a given limb after a simple fracture and its relation to accident insurance companies:

*Fracture of the Femur*.—Out of 155 cases, 8 united in thirteen weeks, 4 died from the fracture. Of the remaining 140, 43 united later, and of these 97 were able to work. In these an average of twelve months and eighteen days passed before they could resume their respective occupations. The higher the fracture, the longer the time required for union.

*Fracture of the Leg*.—Out of one hundred and forty eight cases there were fifty-two that united in the first thirteen weeks. Of the ninety-six others only ninety could be followed up later; of these fifty-nine were able to earn their living in an average of sixteen months. Thirty remained invalid.

*Fracture of the Humerus*.—Out of thirty cases there were eleven that healed in the first thirteen weeks. Of the remaining nineteen ten obtained serviceable limbs, in an average of twelve months and ten days; nine became invalidated.

*Fracture of the Forearm*.—Of sixty-seven there were thirty-six direct recoveries. Out of the remaining thirty one, of which only twenty nine are of statistic value, twenty one obtained serviceable limbs, in an average of sixteen months; eight became invalidated.

These statistics go to show that a much longer time is necessary for healing in these fractures than is generally assumed. Yet a proper after-treatment, on the other hand, will greatly reduce this, as they also demonstrate.—*Deutsche Zeitschrift für Chirurgie*.

**ETHER AS A LOCAL ANÆSTHETIC.**—Koelliker (Leipzig), attempts to restore local anaesthesia by means of ether to its former place. He employs a preparation of the anæsthetic which has a very low boiling point and obtains rapid and complete anesthesia while the pain from the cold is slight. A Richardson spray apparatus is used, the tube held as near as possible to the skin and the spray thrown out with rapid and short compressions of the bulb. It is especially indicated in small operations, as incision of superficial abscesses and felon, boils, extirpation of wens, dermoid cysts and other small tumors, as well as for removal of ingrowing toe-nail, subcutaneous tenotomies and, under certain circumstances, even for laparatomies and herniotomies.—*Deutsche Medicinische Wochenschrift*.

**DISINFECTION OF THE HANDS.**—Reinicke has made a number of bacteriological experiments with regard to the action of the usual antiseptics in the disinfection of the hands. He first rubbed his hands either with spores of a very resistant potato bacillus or cultures of the bacillus pyocyanus. These were allowed to dry

on the hands for an hour and then he attempted to disinfect them. The water was always employed as hot as possible, a liquid soap used and the brush boiled before using. With simple soap and water no results were obtained: the addition of sand also was negative. Solutions of carbolic acid, sublimate and lysol yielded unsatisfactory results. Fuerbringer's method, brushing with soap, alcohol and bichloride solution respectively, each one minute, was also unable to disinfect completely. Alcohol he found to be the only reliable disinfectant, for the hands. If he brushed his hands for five minutes, without previously rubbing them with soap, with alcohol, and then rinsed it off with sterilized water the cultures would be sterile. As alcohol is a very weak antiseptic its property of dissolving fatty substances must be the active factor.—*Berliner Klinische Wochenschrift*.

**SUBCUTANEOUS EXTRIPATION OF TUBERCULOUS GLANDS OF THE CERVICAL, NUCHAL AND SUBMAXILLARY REGION.**—Dollinger (Budapest) reports a method of removing tuberculous glands of the neck, back of the neck and submaxillary regions which is not followed by disfiguring cicatrices. After complete disinfection of the back portion of the head an incision is made into the hairy scalp of the occiput within the edge of the hair so that the cicatrix will be covered, commencing on a level with the external auditory meatus and carrying it downwards and backwards for about five centimetres, cutting also through the fascia. Then by means of an elevator and the finger one may work his way through and under the skin to the nearest collection of glands, grasping a gland with a long and narrow forcep provided with two or three hooks and then drawing out the whole conglomeration one by one. Haemorrhage will be inconsiderable. The lower and anterior margin will become during this manipulation quite distensible, and especially if the head be held towards the operated side it may be drawn deeply down and as the connective tissue around the glands also yields, one will thus succeed in reaching enlarged glands even in the neighborhood of the chin and above the clavicle. The operation is most easily carried out in those where the glands have not been long enlarged and are not softened; so that they lie loosely in the surrounding connective tissue. Healing takes place by first intention most frequently in those cases where the glands have not softened. If the glandular contents be spilled upon the wound-surface it may be wiped out and healing by first intention still follow, though a fistula is liable to persist, which will close after cauterizing it with the nitrate of silver stick. After operation the wound is sutured. The neck generally becomes swollen and oedematous which will disappear in six to eight weeks. Out of nine cases operated on thus he obtained five cases of healing by first intention.—*Medizinische Neuigkeiten*.

**INSUFFLATION OF AIR IN TUBERCULAR PERITONITIS.**—Folet (Lille), records the case of a woman affected with tubercular peritonitis, into whose abdominal cavity he insufflated three quarts of air after having withdrawn six quarts of serum. The effusion did not reappear; her general condition decidedly improved and a cure followed, which has persisted for the last eight months. He calls attention to a similar case reported by Mosetig-Moorhof, who, operating on a child of four years for tubercular lesions in the epididymis, thrust a canula through the inguinal canal, and after withdrawing over three pints of fluid, insufflated air into the peritoneum. A recovery followed which had persisted for five months at the time of reporting. Therefore, in case that laparotomy is found contraindicated in tubercular peritonitis he would advise recourse to this comparatively painless and curative measure.—*Le Semaine Médicale*.

**VINEGAR IN VOMITING FROM CHLOROFORM ANÆSTHESIA.**—Lewin (Brussels) recommends very highly the inhalation of the fumes of vinegar to prevent nausea and vomiting after anaesthesia with chloroform. He lays especial stress upon the details of the method. A piece of cloth of the size of a napkin is placed upon the usual anaesthetizing mask after the operation and the latter gently withdrawn so that the patient does not breathe the pure air but rather that filtered through the saturated cloth. This is permitted to lie there for at least three hours. It is indeed more advantageous to let it remain upon his face for the whole first day. Some of the patients who removed the cloth showed signs of nausea, which soon disappeared on reapplying it. As soon as it dries a second cloth is laid over the first and the latter withdrawn from under the second. If the wet cloth be disagreeable it may be spread upon an inhaling mask.—*Rerue de Chirurgie*. Dr. John C. Morgan has for many years advocated this method (W. B. V. L.).

## GYNAECOLOGY AND OBSTETRICS.

CONDUCTED BY  
GEO. R. SOUTHWICK, M.D.

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**THE TREATMENT OF ECLAMPSIA.**—Prof. Zweifel after an analysis of one hundred and twenty-nine cases under his observation in the Leipsic clinic concludes as follows:

1. In eclampsia during labor delivery should be completed as soon as possible under narcosis. If the conditions necessary for delivery operations are present this rule is trivial, as it has been well established practice, but it is another matter when the cervix is small and the patient cannot be delivered without another operation. It is in these cases that there is a difference of opinion, and formerly most authors counselled delay, but in the light of my personal experience I advise the termination of labor in each case by operative means. There are two conditions to be differentiated—whether the cervix has already expanded and retracted in its upper part, i.e., if the resistance to be overcome is only from about the external os, or whether the entire vaginal portion is intact and undilated.

2. In the first case the cervix can be dilated with a rubber bag like a colpevrynter or with superficial incisions which are practically bloodless.

3. If the cervix is undilated, thick, and only admits the finger, the bags should be used again, and if necessary, the incisions can be made, but they must be deeper, and severe bleeding must be expected in such cases. Haemorrhage follows immediately after labor. I can recommend for its control the application of Billroth's, or other, clamps, the packing of the uterine cavity with sterilized gauze and afterwards the compression of the incisions or lacerations against the pelvic wall with sterilized cotton tampons.

4. Venesection should not be resorted to before delivery in these last mentioned cases as one can not tell how much blood may be lost in this method of delivery. Venesection can be practiced after delivery up to 500 grammes if the eclampsia continues after emptying the uterus, and even before delivery if the pulse has a high tension and the conditions are as in section 3. The old idea that venesection favored rapid dilatation of the cervix is bad practice, which will not be resumed.

5. Unconscious patients should be fed exclusively through the stomach tube introduced into the stomach. The stomach may require washing out in disturbances of digestion. Drinks of lemonade, tartaric acid, or vinegar can be poured into the stomach. Vegetable acids are decidedly beneficial and should be used freely and will do no harm if properly used. Tartar emetic and calomel were formerly used to empty the stomach and intestine, but I prefer to use the stomach tube, especially in vomiting and diarrhoea. After the stomach is washed out I pour in the stomach a solution of citric acid 2.5 g. and aqua fontana 500.0 g. Or acidi tartaric 2.5 gs. Aq. fontani 3.0.0 g. Syrupi rubi Idaei 30.0 g. Vinegar is another remedy in the shape of acidi acetici diluti 2.5 g. Aq. fontani 2.0.0 and syrup of sugar. All three acids have the power of dissolving deposits of albuminoids and is founded on the evidence of pathological anatomy which has demonstrated that in eclampsia there are many thromboses in the blood, in the liver in the lungs, and in the brain, which certainly mean that some poison has entered into the circulation of the blood and caused the clotting. Citric acid and tartaric acid have the advantage that they can be prescribed in powder form and be dissolved in the stomach. The diuretic effect is not worth considering.

There should never be any delay in the induction of premature labor when the nephritis of pregnancy is present.

Morphine for restlessness and tossing about has been abandoned and it has not been used for three and a half years.

6. Either ether or chloroform can be used for an operative delivery.

7. The strictest asepsis must be observed, as infection keeps up the convulsions.  
—*Centralblatt für Gynäkologie.*

**CHILDBIRTH THROUGH A CENTRAL PERFORATION OF THE PERINÆUM.**—The patient was a Russian, 19 years old, who had been delivered outside the hospital, six days before admission into the clinic, without the aid of a midwife or physician. The child was born alive, but died on the following day. Examination revealed the following condition: previous history and present appearance that

of a healthy primapara ; Mons veneris and large and small labia well developed ; clitoris a little hypertrophied ; the vulvar orifice scarcely allows the the passage of a finger ; the urethral orifice is not visible externally ; the hymen is extremely small, and slightly torn posteriorly ; the whole vulva appears as if it were pressed in ; the perineum is of abnorma length (7 cm.), and in the centre of it there was an irregular tear communicating with the vagina, which was also torn on the posterior wall. The anus was not injured.—*Centralblatt für Gynäkologie*, No. 23, 1895.

**RESECTION OF THE OVARIES**—Matthiæ.—This operation is recommended :

1. In cases where there are numerous large retention cysts which cannot be cured by puncture. 2. For dermoid cysts. 3. With great care for large proliferating glandular cysts of a benign character. This conservative operation is absolutely contra-indicated if there is (a) malignant disease of the ovary, either present or suspected ; (b) in women who are at or near the climacteric.—*Ibid.*

**TARTARIC ACID FOR THE REMOVAL OF BLOOD FROM THE HANDS, SPONGES, ETC.**—Benckiser draws attention to the difficulty of removing blood stains from the hands after an operation, especially if sublimate solutions have been used which throw down the coloring matter of the blood as an albuminous brownish precipitate on the skin. Tartaric acid easily removes it. Laplace showed that the addition of tartaric acid added to the effectiveness of sublimate solutions with albuminous fluids, such as wound secretion or blood, as it inhibited the depositing of the insoluble albuminate of mercury. It was tried in Bergmann's clinic and abandoned in surgery as the absence of the protecting deposit of the albuminate on the wound gave rise more easily to mercurial poisoning from absorption on the free wound surface. Its peculiarity of holding albuminous fluids and especially blood in solution makes tartaric acid very desirable for the personal toilet as well as for the removal of blood from sponges, instruments, brushes, dressings, clothing, etc. He recommends a coffee-spoonful, about three or four grammes, to a washbowl of lukewarm water.—*Ibid.*

**TREATMENT OF ECLAMPSIA.**—Conclusions by Palock : 1. Eclampsia is due to a toxæmia in which the entire excretory system plays a part.

2. Constipation bears an intimate relation to this toxæmia.

3. A pregnancy-nephritis is frequently coincident with the occurrence of convulsions, and, that an albuminuria is of much less importance than a diminution in urea and total solids eliminated, or a decrease in the amount of water passed in twenty-four hours.

And finally, that while diaphoretic, cathartic, and dietetic measures often improve a nephritis of pregnancy, the woman is never safe with the *fetus in utero*; therefore, the gestation should be terminated in the most surgical manner.—*Am. Gynaecological and Obst. Journal*.

## OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

CONDUCTED BY  
CHAS. M. THOMAS, M.D.

**EXTERNAL EXAMINATION OF THE LARYNX.**—Gerhardt enumerates in concise form the various diagnostic points which can be evolved by external manipulation of the larynx and the anterior portion of the neck. In severe dyspnoæ, from narrowing of the calibre of the larynx, the latter manifests strong movements synchronous with respiration, while in tracheal stenosis it is generally quiet. In the former case the head is generally bent backward, while in the latter the chin approaches the sternum. In persistent stridor the finger lightly placed upon the cervical portion of the trachea feels a corresponding "whirring," which in laryngeal obstruction is more often inspiratory, or at least stronger in inspiration, while in deep-seated tracheal trouble the after-felt whirring is more often alone expiratory or stronger in expiration.

Gerhardt also discusses the value of tracheal pulsation as an evidence of aneurism and relates a new case of pulsation of the larynx.

The latter part of the article considers paralysis and spasm of the larynx in their relations to external palpation. A case is related of a woman who, after amputation of the thigh for sarcoma, suffered from metastatic deposits in the lungs and pleura. There soon supervened expiratory adduction of the cords with rapid tremulous movements. Autopsy showed a hen's-egg-size sarcomatous mass in the right frontal bone, which, with the thickened dura, had caused a depression about 2½ cm. deep in the right middle and inferior frontal convolutions of the brain. Gerhardt surmises that the tremulous movements of the cords were caused by the involvement of the right cortical centre of the larynx.—*Archiv. f. Laryngol.*, vol. ii., No. 3, p. 281.

**IGNATIA IN SUPRAORBITAL NEURALGIA.**—Dr. Townsend reports a case of supraorbital neuralgia of the right side, of years' standing, occurring in a male of 22 years. The pain was "sharp, intense and agonizing" in character, lasting from one to two hours, accompanied by engorgement of the conjunctival vessels of the same side, and followed exposure to drafts of air. The pain commenced over the right eye and extended toward the temple of the same side. The patient's general health was unimpaired; vision good, with slight astigmatism. A cure, which has attested its permanency by a complete absence of the pain for the past three years, was effected by the exhibition of a few doses of ignatia 6.—*N. A. Jour. Hom.*

**A CASE OF TEMPORARY AMBLYOPIA FROM CHOCOLATE.**—Dr. Carey A. Wood cites a case of a physician, aged 54, who, in a period of twenty years, had suffered from over one hundred attacks of migraine accompanied by amblyopia, and the result of the ingestion of chocolate. The symptoms were as follows: A wheel like, confused, whitish (not colored) mass, rotating in front of both eyes, and gradually increasing in size and density until the visual field was covered, and he became practically blind. For ten minutes not even the largest objects could be perceived, there being only perception of shadows or ability to count fingers at a few inches. Later, vision was partially restored, the outlines of large objects, as houses and vehicles, being perceived. In half an hour smaller objects became visible, and at the end of one hour the patient could see as well as ever. The attacks were always accompanied by vertigo, intense nausea, severe pain in, and a sense of pressure upon, the head.

During the long period mentioned the patient had, from time to time, referred the attacks to various articles of food taken, and had abstained from each in turn until satisfied that he was mistaken. Finally, an attack supervened immediately after eating some chocolate, and by further experimentation he became convinced that this was the sole cause.

Chocolate in blocks, or as creams, in cakes, in suspension as a drink or in ice cream, invariably precipitated an attack, the severity of which was proportionate to the amount of chocolate taken. He has been able to associate every seizure he has had for the past few years with the previous eating or drinking of chocolate in some form, and he has had no attack not preceded by such indulgence. He is positive that a moderate use of cocoa does not affect him. It is now over a year since he ceased taking chocolate in any form, and during this period he has been absolutely free from the infection.—*Med. Record.*

**EFFECTS ON THE EAR OF NASAL STENOSIS.**—Dr. Randall claims that the discomfort and impairment of hearing which often accompany acute coryza in its early stages cannot be attributed to stenosis of the Eustachian tube or to its being filled with secretion. On the contrary, the nasal obstruction is nearly always far anterior, the region about the mouths of the tubes not being at all involved, while the disturbance may be vasomotor rather than inflammatory. The aural symptoms are due, of course, to rarefaction of the air within, and consequent external pressure upon the drumhead. This, in turn, is due to the constant partial emptying of the middle ear by the act of swallowing while the nasal canal is closed; in other words, the performance of the Toynbee experiment. Strong inhalation while the nose is obstructed produces the same effect, while painful suction under these conditions is a symptom of an inflamed antrum. The author recommends, for the permanent relief of this condition, cleansing with an alkaline spray, the application of an oily menthol-camphor solution, after which the inflamed surfaces are dusted with mercurius chloride.—*Phila. Polyclinic.*

## MONTHLY RETROSPECT OF HOMEOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D.,

FRANK H. PRITCHARD, M.D., AND F. MORTIMER LAWRENCE, M.D.

**GÉNANTHE CROCATA IN EPILEPSY.**—Dr. V. Rappaz was consulted with regard to a young girl of ten years who suffered for three years from epilepsy, and who under distinguished allopathic treatment had steadily grown worse; the seizures gradually increasing in frequency and intensity. The patient was depressed, pale, and without appetite from overdosing with various bromides. April 1<sup>st</sup>, she received génanthe crocata 6 cent. dil. No attacks until May 12<sup>th</sup>, when a slight seizure occurred. June 3<sup>d</sup>, she had a mild seizure of vertigo, without losing consciousness. The twelfth dil. was then given, and no other attacks appeared. She has entirely regained her health.—*Boletin de Homeopatia*, 1895.

**KALI BICHROMICUM IN OSSEOUS DISEASES.**—Dr. Ide has had rapidly curative results in a case of ossifying periostitis of the right femur, which had persisted for two years, in a male who had several times been operated on for his disease. There was a great thickening of the bone, with several fistulous ulcers upon the skin. There was no history of syphilis. Kali bichromicum 10x healed the process in two months. It has been asserted that this remedy has no action upon the osseous system, but only upon the cartilages and periosteum. Dr Grubemann reports a case of recurring caries of the tibia which he successfully treated with the same remedy. In these cases one should also bear in mind arg., aur., calc., fluor., kali iod., merc., mezer., nitr. acid., phos., phosphor. acid., silica and strontium carb.—*Zeitschrift des Berliner Vereines Homeopathischer Aerzte*, xiv., Bd. Hft. V., 1895.

**ACALYPHA IN HÆMORRHAGES.**—At the Hôpital St. Jacques, Paris, acalypha has been found to be an active remedy in hæmoptysis and uterine hæmorrhages. In one woman with hemorrhages from a fibroma, which had lasted for several months, and where hydrastis, sabina, etc., had failed, this drug brought about, after a dose of six drops of the tincture, a rapid cessation.—*L'Art Médical*, No. 10, 1895.

**ETHIOPS MINERALIS**—This remedy, a compound of sulphur, mercury and antimony, is especially recommended in scrofulous ophthalmia, in chronic otorrhœa following scarlatina, and in facial eczema, with ichorous secretion, in scrofulous children.—*Ibidem* [Dr. H. Goullon speaks highly of this remedy in the 1x, 2x or 3x, as a valuable remedy in scrofulous ophthalmia, especially in its pernicious forms, where "it will be seen to distance all its competitors."—*HAHNE-MANNIAN MONTHLY*, Oct. 1895.—Eds.]

**IODOFORM IN TUBERCULAR MENINGITIS.**—In a paper, read before the Meissen Club of New York and printed in the *N. A. Journal of Homeopathy*, February, 1896, Dr. William S. Miner first refers briefly to a case reported by him in September, 1887, in the *New York Medical Times*. In that patient, a little girl aged 4, tubercular meningitis followed two months after an attack of measles. *Belladonna* and *aconite* alike failed, and the disease was rapidly approaching a fatal termination when Dr. Miner determined to make a trial of the treatment recommended by Dr. Eugene Martel (*Revue Internationale*), viz., iodoform by inunctions. Dr. Martel had reported seven cases cured by this method. Accordingly, the child's head was shaved, a pomade was made of iodoform, 3*ij*; to vaseline, 3*j*; and one-half drachm of the ointment was rubbed into the scalp twice daily. In

addition the tincture of veratrum viride was administered in drop doses hourly, and the bromide of sodium was used at night only in alternation with it. The improvement was remarkable. The child, totally blind, deaf and unconscious, with a temperature of 104.4°, was in four days vastly improved, with the temperature reduced to 98°. From this the temperature remained normal for several days, and the child improved daily. *Veratrum* was discontinued and *sulphur* substituted. The power of speech and the appetite returned. With the fall of the temperature to normal an eruption of boils made its appearance upon abdomen and thorax; they increased in number and size daily, until the entire surface of the thorax and abdomen, anteriorly and posteriorly, was covered with them. The inunctions of iodoform were then discontinued and *hepar* 3x administered. A moderate degree of fever, 100° to 102°, was present with these boils. In the course of a few weeks, however, the boils disappeared, no meningeal symptoms returned, and the child grew fat and strong. Dr. Miner kept track of her for three years and she remained perfectly well.

A second case, one of traumatic meningitis following fracture of the skull, was seen by Dr. J. F. O'Connor in consultation. The condition was so unfavorable that he gave an unfavorable prognosis, but suggested the use of *iodoform*, a powder of the sixth decimal trituration to be given four times a day, in addition to *bella-donna* third, which was then being administered. The iodoform was obtained the following morning and its use begun. That night the temperature did not get quite as high as formerly, and the next morning was lower. Some improvement was noticed daily after this time, and in a few days the temperature was normal and consciousness began to return. When the patient regained consciousness it was found that she had lost her memory for words; she could not remember the names of those about her, and she could scarcely remember enough words to make herself understood. But under the continued use of *iodoform*, 6x trituration, all the symptoms gradually cleared up. *Magnesia phos.* 6x, used intercurrently at times had a wonderful effect in stopping the sharp pains in the head.

Dr. Miner's third case is a remarkable one. On October 27, 1894, he was called by a Swede to see his little girl, who had for ten days been suffering with what was finally determined to be tubercular meningitis. Three physicians had already given an unfavorable prognosis. Dr. Miner determined to make a further test of iodoform, and as he had gotten such satisfactory results from iodoform administered internally in traumatic meningitis, he thought he would first test its internal use in the tubercular form of the disease. He had none with him, however, and as *cdc. phos.* seemed to cover many of her symptoms he prescribed that, expecting to bring the iodoform in the morning. That night the child, who was six years old, had convulsions almost all night, coming on at midnight and lasting until nearly morning; the parents did not think she would live through the night. *Iodoform* 6x was prescribed, a powder every two hours. This was continued for a week without satisfactory improvement, the convulsions having continued at intervals and the other conditions remaining unchanged. On November 3d, *iodoform* 2x, a powder every two hours, was directed. The following night convulsions again occurred, and on his visit the following morning Dr. Miner found the condition unchanged and the mother in tears beside the bed. In response to his inquiry she explained that she wept because her little one could not recover, and then confessed that without the physician's knowledge she had had no less than eight other physicians beside himself. Among those she mentioned having consulted, one was a professor in the New York Post Graduate Medical School, and another, whom she said had gone away just before Dr. Miner came in, was professor of the diseases of children in one of the foremost medical schools of New York. All concurred in pronouncing the case one of tubercular meningitis, and all agreed that the child would die.

As the iodoform given in the form of triturations had thus far failed to produce any material improvement, Dr. Miner now concluded to use it in the manner that had formerly proven so successful. Accordingly he directed the child's head to be shaved, and one drachm of an ointment of iodoform 3j to vaseline 3j to be rubbed into the scalp twice a day; it was to be thoroughly rubbed in until it disappeared.

From this time on the condition of the patient began to improve. She had no more convulsions, she slept more quietly, and she took more food. At the end of a month the application of the ointment was directed but once daily, and a week later she was discharged, cured. Six months later the child was absolutely well; her mother said she had never been in better health. At no time was a dose of

any other remedy used with the exception of two doses of castor oil, given when the bowels were very much constipated.

In conclusion, Dr. Miner refers to the article by Dr. Clarence Bartlett in Goodno's *Practice*, published since his last case was treated. Dr. Bartlett says: "Among remedies, iodoform stands at the head. This drug has in several instances (I have twice observed it to do so) produced symptoms indistinguishable from meningitis. It is customary with the old-school physicians to shave the scalp and apply an iodoform ointment for two or three days. The internal administration of the drug will probably do as much if not more good. I have used it in the second decimal trituration giving one tablet every two hours." Dr. Miner's experience leads him, however, to prefer the inunction method.

**SOLANUM CAROLINENSE IN EPILEPSY.**—In 1889 Dr. Napier called attention to *solanum carolinense* as a remedy in the treatment of epilepsy, stating that it was used as a domestic remedy in the South for convulsions and "that he had successfully prescribed it in his practice." Dr. Charles S. Potts, of the University of Pennsylvania, contributes a paper (*Therapeutic Gazette*, December, 1895), on the remedy, giving some new points, from which the following is condensed.

At the clinic for nervous diseases of the University Hospital, *solanum carolinense* was tried in a series of twenty-five cases, twenty-one of which were idiopathic, three organic, and one probably so. Of these, eight of the idiopathic cases either did not return after the first visit or else were not under observation sufficiently long to offer a fair test. In the remaining seventeen cases the following results were obtained, viz.: five, two of them organic, were not improved. In the remaining twelve the results showed more or less benefit from the use of the drug. The five cases in which no improvement was noted were afterward placed upon other treatment, either antipyrin and bromide of ammonium or the mixed bromides, with amelioration of the symptoms in four; in the remaining one no drug seemed to be of service. The dose used at first was ten drops. This dose was found to be useless, and after the first few cases they varied from thirty drops to a teaspoonful three or four times daily. No unpleasant effects were observed, excepting a mild diarrhoea in some cases. This was also noticed by Dr. Herdman. He also noticed that in large doses the temperature was lowered and the pulse slowed. In many epileptics diarrhoea is more of a benefit than otherwise.

The conclusions, derived from the results obtained in seventeen cases, are:

1. That the drug has a decided influence for good upon the epileptic paroxysm.
2. That this influence is probably not so great or so sure as that obtained by the use of antipyrin and the bromide salts, or even of the mixed bromides.
3. That in those cases in which it is of service it relieves the paroxysms without causing any other unpleasant symptoms, such as are sometimes caused by the use of large doses of the bromides.
4. That the dose ordinarily recommended is too small, and that as much as a teaspoonful, or more, four times daily is often needed to secure results.—*Hom. Recorder*, January 15, 1896.

**AGARICUS IN ASTHENOPIA MUSCULARIS.**—Dr. G. W. McDowell records the case of a seamstress, st. 35. General health good. Complains of eyes feeling tired and giving out after long use at her work. She has been subject to sick headaches. Examined eyes and prescribed a 0.50 D. S. glass for constant use. This relieved her eyes while she was not working. Pathogenetic symptoms: Eyes ache; twitching of the lids. *Ruta* and *natrum mur.* gave no results. *Agaricus* was prescribed because of the twitching of the lid. At the times when the eyes ached she was relieved by the drug. A month later reports that she is able to use her eyes constantly without pain in her work, and no more twitching of the lids.—*N. A. Journal of Homoeopathy*, February, 1895.

**APIS MELL. IN URTICARIA.**—Dr. W. S. Mills records the case of Miss Q., st. 28, bookkeeper. Has had an eruption for two years. Many lotions and ointments recommended by friends and prescribed by physicians have not benefited her. Due attention has been given to her diet for weeks at a time. Pathogenetic symptoms: Numerous wheals, pinkish in color, freely distributed over the body, itching intolerably; worse from warmth; they feel like stings. Clinical symptoms: Aggravation from warmth of the bed at night, relieved by scratching. *Apis mell.* given December 16, 1-91, with marked relief. January 1<sup>st</sup> gave *apis* 3 in powder. Complete cure resulted. In July, 1894, and June, 1895, patient

had a return of the eruption, and each attack was promptly relieved by *apia*. No adjuvant treatment was used either time.—*N. A. Journal of Homœopathy*, February, 1896.

**ARSENICUM IN TOXIC AMBLYOPIA.**—Dr. G. W. McDowell reports the case of D. M., et. 48, married, a laborer. Vision had been failing for the past eight months. General health good. Smokes a great deal of tobacco. Drinks but little. Vision O. D.  $\frac{1}{2}$ ; O. S.  $\frac{1}{2}$ . No improvement from glasses. Pathogenetic symptom: Impaired vision. *Arsenicum* 3x was given for six weeks, during which time he smoked less than formerly, but did not stop at any time. At the end of the treatment the vision was  $\frac{2}{3}$  in both eyes.—*N. A. Journal of Homœopathy*, February, 1896.

**CLINICAL NOTES.**—*Rhus tox* is especially valuable in erysipelas of the eyelids above all if it be of traumatic origin.

*Rhododendron* has been found useful in ciliary neuralgia when the pain aggravates before bad weather.

*Pulsatilla* is the remedy for affections of the lachrymal sac, especially in the beginning of phlegmonous dacrocystitis.

*Mercurius corrosivus* is indicated in episcleritis, with pain in and around the orbit.

*Kali iodatum* is a remedy especially valuable in orbital periostitis, if it be of syphilitic origin. The pain may be very violent or totally absent.

*Sepia* is very useful in follicular or trachomatous conjunctivitis.

*Jaborandi* is to be compared with physostigma and agaricus in spasm of accommodation. It may be used to counteract duboisin.

*Ruta graveolens* is more indicated in insufficiency of the ciliary muscle than that of the internal rectus. At night the eyes feel like two balls of fire. Pain in the eyes after using them.

*Chromic acid* is the best remedy, internally, in chronic hypertrophic catarrh.

*Thuja occidentalis* is said by Dr. H. Gouillon to be indicated where the patient is sleepless from a host of ideas crowding upon the brain—nervous insomnia.

*Sulphur* is to be thought of in febrile affections, where aconite does not act and the fever is prolonged.

*Conium* is to be thought of in hypertrophy of the tonsils, when baryta carb., calc. carb., etc., have failed.

*Glonoin* is an excellent remedy to remove the bad effects of subcutaneous injections of cocaine.

*Sabadilla* in hay fever is not to be neglected.

*Cypripedium* in the insomnia of children, when after having slept a few hours they awaken perfectly awake—wide awake—without any apparent reason. If it manifest itself after three in the morning, of course *nux vom.* is the remedy.

*Pulsatilla*, though not a specific in pulmonary tuberculosis in women, is a remedy not to be passed over lightly.

*Capicum*, in the treatment of delirium tremens, in the beginning, is a useful remedy, which must, however, be administered in the tincture. Its results are not only satisfactory but surprising.

*Eryngium aquaticum* in renal colic is a drug to be consulted. In a chronic and recurring case, five drops of the tincture, three times a day, produced a cure.

*Cinnabaris* 3c., in a child of six months, with diarrhoea, and in whom hereditary syphilis was suspected, produced a cure after *mercurius sol.* had failed.

*Mercurius corrosivus* is a true specific in the albuminuria of pregnancy.

*Ceananthus croceus* cured two cases of epilepsy of six and ten years' duration respectively, after a preliminary antipsoric treatment of nine months, with sulph., thuja and psorinum.

*Bryonia* is able to cause as severe colicky pains as colocynthis, and they are always accompanied by diarrhoea.

*Cimicifuga* and *Caulophyllum*.—If the cardinal principle of *cimicifuga* in its pathogenesis be tonicity, then that of *caulophyllum* is atony.

*Lilium tigrinum* also has the characteristic heart symptom of *cactus*, a sensation as though the heart were held in a hand of iron, which alternately opens and closes.

*Eupatorium*, like *bryonia*, has a cough that forces the patient to hold his head when coughing to prevent it from feeling as if it were about to fly to pieces.—*Journal Belge d'Homœopathie*, No. 5, vol. ii., 1895.

# THE HAHNEMANNIAN MONTHLY.

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MAY, 1896.

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## ON THE NATURE AND ORIGIN OF CERTAIN FORMS OF CHEST PAIN.

BY EDWARD R. SNADER, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

MY relation with the Heart and Lung Department of the Hahnemann Medical College, Philadelphia, has brought me in direct contact with a large number of cases that were symptomatically characterized by pain in the chest. "Pain in the chest," I am quite aware, is an extremely vague, and possibly misleading, expression; but the expression itself is not more vague than was my understanding in former years of the nature and origin of certain mysterious and painful sensations in the thoracic region complained of by patients. My patients were not diagnosticians, and they came as near the truth as I did, in many instances, when they characterized their cases as "pain in the chest." I do not, of course, mean that all the cases of pain in the chest that I came in contact with were inexplicable, in a diagnostic sense; but I do mean that I made countless examinations, skilfully and elaborately conducted, in my endeavors to discover the source of sensations that were painful and referred directly to and located by the patients

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themselves on the anterior portion of the chest. The front portion of the chest was nearly always complained of. Sometimes patients would speak of a pain going through the chest or between the shoulders. In other words, while I many times found diseased conditions, I many times did not, when pain was complained of. Sometimes lesions were discoverable that logically justified the existence of pain as a specific symptom. Such cases were easy enough; but when, after a painstaking examination, no conditions were found to account for pain, the diagnostic problem was at least hazy.

The pains in the chest had all sorts of characters and all manner of modalities, as cutting, stitching, lancinating, knife-like, tearing, thrusting, twisting, screwing, pressing, plugging, stinging, bruising, boring, burning, tingling, etc., some worse from motion, deep breathing, coughing, sneezing, eating, some better from motion, warmth, cold, etc.; sometimes with external hyperesthesia, sometimes not. But, with all this side information, many of these pains were still inexplicable. Of course, I wish you to understand that these pains were distinctively thoracic in seat. I do not now refer to the suffering in the chest induced by manifest or obscure maladies affecting the gastric or gastro-enteric apparatus. Pains in the chest from such causes are common enough, and usually offer little difficulty in diagnosis. But, when you have physically explored a given case that has pain in the chest as a prominent symptomatic character, and you find the trachea, the bronchi, the lungs, the pleuræ, and the heart normal, and are still confronted with an apparently causeless sensation of pain, you are somewhat discouraged at the outlook, particularly if you are fond of attempting to understand precisely the nature of your patient's malady, and are not satisfied with the knowledge of your case unless you have tracked each salient symptom to its anatomical source, sometimes through a labyrinth of vague symptomatology and a multiplicity of complex conditions.

The experience of not finding anything, or sufficient, to explain the existence of pain, occurred so frequently that it dawned upon me at last that many of the pains did not arise from the interior of the chest at all, and that chest pains could exist without any discoverable anatomical basis in either the respiratory or cardiac organs, and frequently not in the nearly

related organs, above the supra-sternal notch or below the diaphragm.

At this stage of the investigation I summed up the situation about as follows; Pain in the chest could exist without any disease whatsoever of the thoracic organs; pain in the chest could exist as a distinct local disease; pain in the chest could exist as a reflex as the result of the functional or organic derangement of almost any organ of the body. With these tentative assumptions it was easy to come to the working conclusion that the major portion of chest pains were external, or relatively so at least; *i.e.*, that the nobler thoracic organs themselves infrequently, as regards the total number of cases of chest pain, declared their disorders in pain, and when these organs did cry out in their maladies, the diagnosis was readily made. This conclusion, however, forced another—namely, that many of the pains must, of necessity, be relatively external; that is, in the chest walls or in their supplying sensitive nerves. I began, therefore, to examine the external chest with more care than before. Of course I found, as I had previously, a few cases of myalgia. With my working hypothesis, however, of the possible implication of the sentient nerves, I paid more attention to the posterior portion of the chest, although the most frequent seat of pain complained of was the anterior portion of the chest, particularly the left, and in the region of the heart, and sometimes between the shoulder-blades. I discovered, by carefully-conducted point-pressure, that in about 95 per cent. of all cases of chest pain, not due to gaseous distension of the stomach, and consequent upward pressure against the diaphragm, with resulting thoracic discomfort—no matter where located or what their character—that there were points of tenderness where the nerves had their exit from the spinal column. I also found along the corresponding rib a similar point in the mid-axillary line and one on the anterior portion of the chest—three points in all. Sometimes there was extensive hyperæsthesia, sometimes not. These tender points were at first found with the greatest difficulty until I had gained considerable experience in knowing where to look for them and what degree of pressure to employ. Very few of the patients knew they had a “sore spot” behind until I touched it. Sometimes, if the pain were low in the chest, the front tender point would be found

low down, near the umbilicus. In pains at the superior portion of the chest I have sometimes found the posterior tender point high up in the neck. Occasionally there are only two points to be found. This is particularly true of upper-chest pains.

Now these tender points are the Vallieux diagnostic features of neuralgia—*intercostal neuralgia*. It was stupid of me, no doubt, to be so long in the dark as to the nature of these pains, with these diagnostic features almost biting my examining fingers; but in those early days I trusted to text-book teaching. I had recognized intercostal neuralgia before my discovery of the frequent presence of these tender points in cases of chest pain, but the cases were typical and offered no especial difficulty. But the text-books compelled me to find typical neuralgic pains, and on that rock I split. You will not quarrel with me, I think, when I tell you that I consider any character of pain or unusual sensation in the thorax characterized by the three tender points as neuralgia.

Why should a nerve always tell of its suffering in one language? It may express all the shades of its pain capabilities along the same nerve trunk, and I should be able to recognize these variations in the character of pain and sensation just as I should know different modulations of the same voice. I shall recognize various kinds of pain as neuralgia so long as I can discover by these three tender points that the spinal nerve is the offending member.

Does the discovery that the vast majority of chest pains travel along distinct nerve trunks have any practical value? Is it of any service to know that these intercostal neuralgias are the cause of chest pains? I reply most emphatically, yes; both diagnostically and therapeutically.

You will see that I am right in this emphatic declaration when I tell you that there are more errors in diagnosis made in consequence of the misunderstanding of the nature of these pains than can be laid to the blame of any one single factor connected with the diagnosis and treatment of thoracic diseases. Pain is so frequent an accompaniment of diseases within the chest walls, and the fact that pain may exist without such disease or may exist as a reflex from some distant disease, that the forgetting of the last two factors leads the unwary into to assuming that some grave disorder is present.

*Intercostal neuralgia* frequently accompanies and is part of the symptomatology of such grave diseases as phthisis pulmonalis, pleuritis, pneumonitis, pericarditis, valvulitis, angina pectoris, and aortic aneurism. I have known all these diseases to be diagnosed, the main feature of the diagnostic criteria having been the pain, when in reality the neuralgia, instead of being a part of the symptomatic picture of disease, was itself the only disorder present. It is next to impossible not to appreciate the importance of such overwhelming blunders in diagnosis.

*Intercostal neuralgia*, existing alone for a considerable period of time, can, by the very persistence of the pain, induce such secondary revolt in the nervous and other great systems of the economy, that the most dire pictures of grave disease are formed. I have so frequently seen such counterfeit pictures that I know it is not possible to overestimate the conception that an intercostal neuralgia may alone be the cause of the gravest error in both diagnosis and therapeusis. I am sure if you had had my experience in this matter, you would also embrace my views.

Angina pectoris has been diagnosed when the affection was simply an external neuralgia, and the likeness to the dire disease simulated by the comparatively innocent pain has been wonderful. I have, indeed, seen the two affections associated, and have been able by the face alone to differentiate between the paroxysm of pain due to the soul-harrowing angina and the intercostal neuralgia. When pain is present after the consolidation is complete in lobar pneumonia, and also when the fluid is effused in pleuritis, it is due, in the vast majority of instances, to an associated or symptomatic intercostal neuralgia. Indeed, I have found these pains in the very incipiency of these diseases, not attributable, I think, to the inflammation of the pleura or the lung.

Intercostal neuralgia is the cause of about 90 per cent. of chest pains occurring in the course of phthisis pulmonalis. It is, at some stage of the disease, a more or less constant accompaniment; for the stitching pains due to secondary pleuritis (and pleuritis often, indeed, occurs without them) are exceedingly transitory in the onward progress of pulmonary consumption, and are readily diagnosable by their very definite association with signs of consolidation.

The limitation of the matter to a brief paper permits me to discuss this subject in only the broadest way. If I were to particularize, and cite clinical cases, I am sure I could write a volume. When the wonderful variation in the character of pain, the obscurity of its associations, and the multiplicity of accompanying diseases, you will see with me that there is the greatest possible chance of error in failing to discover the nature of chest pain, and equal chances of making a mistake in attributing the pain to a wrong pathological condition.

I have found intercostal neuralgia in connection with all the so-called general diseases affecting the body, and with many so-called local affections, and that, too (although not invariably), without involvement of the pleura, lungs or heart. It behooves the general practitioner, then, to be on the lookout for these pains. Their general prevalence proves the universal interdependence of the economy upon its integrity as a whole, and how much the nerves of distant parts tell the story of disease somewhere. In the order of occurrence intercostal neuralgia (or chest pains, with characteristic tender points, if you want to be excessively exact) are most frequent in phthisis pulmonalis, valvular heart disease, bronchitis, uterine disease, liver and gastro-intestinal maladies, lithæmia, rheumatism, syphilis, Bright's, affections of the upper respiratory tract, disorders of the lower intestinal canal and the urinary passages. It occurs in anæmia, and also in those diseases in which the blood is surcharged with self-made or introduced poisons.

Exceptionally, intercostal neuralgia exists to such a decided degree, in connection with other maladies of which it is a complication or symptom, that it demands special control. Here comes in the importance of these pains, in a therapeutic sense. Many of these pains are incorrigible to treatment, although you may be scientifically and persistently attacking the underlying cause. If you will tear out a leaf from my book of experience, you will treat the severe cases locally, by applying the medicament to be employed for the relief of the pain directly on and over the posterior tender point. Treatment over the portion of the structures supplied by the nerves, that is, anteriorly, seldom, if ever, does good. Sometimes it aggravates. Attack the pain at the foramen of exit of the nerve from the spinal cord.

Intercostal neuralgia is often double, that is both sides are attacked, sometimes at the same, sometimes at different levels. Several nerves on the same side may be affected at once, and very exceptionally all of them. You will sometimes note that the nerve on the unaffected side shows some tenderness to palpation without, however, producing pain in the front of the chest. This is probably a sympathetic involvement. These tender points remain, too, for a considerable time after the subsidence of pain. The patient is not at all aware of their presence; your palpating finger alone discovers them. Do not always expect your patient to wince when you touch these sore spots. When you have discovered one, press in the immediate neighborhood, and distinctly localize the soreness in one spot, avoiding all possible chances of error. Hunt for the other points along the border of the corresponding rib. In hyperesthetic areas, by careful comparison you will be able to find the *most* tender point. In about 85 per cent. of cases the neuralgia is on the left side of the chest.

The diagnosis of the presence of an intercostal neuralgia itself is one of the easiest things in all medicine; but, when you have discovered your tender points, you are simply opening the door of the diagnostic problem. Is the neuralgia the whole of the disease story? will be the first question. If it is not idiopathic, of what particular disease is it symptomatic? The answer to this second question not infrequently demands the most thorough and exhaustive examination of the patient from head to foot. The question can be answered in the vast majority of instances, I am sure.

I shall endeavor to sententiously summarize some of the leading points I have learned about chest pains.

Ninety-five per cent. of all chest pains are due to intercostal neuralgia.

Intercostal neuralgia exists as an idiopathic, as a secondary and as a symptomatic affection.

Intercostal neuralgia, existing as a prominent feature of a case, is capable of producing deceiving clinical pictures.

Intercostal neuralgia accompanies most frequently disorders affecting the heart or lungs.

Intercostal neuralgia, as a reflex can be present in almost any disease not distinctively thoracic, accompanied by nerve deterioration or blood changes.

Intercostal neuralgia alone, can be mistaken for the most diverse maladies ; and, as a complication or sequence of a given disease, can so dominate the symptomatology as to lead to errors in diagnosis and mistakes in the application of therapeutic measures.

The character of pain or sensation is not diagnostic, but the implication of a nerve trunk is.

Three and sometimes two tender parts discoverable by palpation at the foramen of exit of the nerve along the spinal column, in the mid-axillary line and in the anterior portion of the chest, are the diagnostic features of intercostal neuralgia.

That simple, every-day intercostal neuralgia is most frequently mis-diagnosed as pleurisy, next as pneumonia, next as heart disease, next as phthisis, next as angina pectoris, and next as a uterine reflex.

The three lessons that I wish particularly to enforce by this brief paper are : That intercostal neuralgia is the cause of 95 per cent. of all cases of chest pain, and that idiopathic intercostal neuralgia is frequently mis-diagnosed as grave disease, and that serious as well as minor affections have intercostal neuralgia as one of their manifestations.

In cases in which chest pain is a prominent or persistent symptom, and there is no slight or gross disease discernible within the thorax, *i.e.*, in the heart, lungs, pleurae or bronchi, and intercostal neuralgia, or neuritis or neuroma are absent, it will be necessary to differentiate rheumatism of the fascia, myalgia, caries of the ribs or vertebræ, and spinal diseases, as meningitis and locomotor ataxia.

Herpes zoster accompanies intercostal neuralgia, as an exceedingly rare occurrence, in my experience. When it is associated, the case is generally one of neuritis.

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DIMINUTION OF FLUIDS IN BROKEN COMPENSATION IN HEART DISEASES.—Dr. Glax, in cases of broken compensation in chronic valvular affections or lesions of the myocardium where the usual heart tonics fail, advises limiting the quantity of fluids ingested. At first one may begin with a litre a day and gradually reduce the amount to 900, 800, and even 700 grammes daily, after toleration. The amount of urine increases, the dyspnœa decreases, the œdema diminishes and the heart not having such a burden to manage, grows stronger. In some cases, this will of itself suffice to restore compensation ; if insufficient, then follow with heart remedies.—*La Semaine Médicale*, No. 48, 1895.

## A CONTRIBUTION TO THE ACTION OF OLEANDER UPON THE SKIN.

BY F. H. PRITCHARD, M.D., WEAVER'S CORNERS, OHIO.

OLEANDER, though a drug endowed with decided toxic and consequently therapeutic properties, is a remedy of which but little is heard of in homœopathic literature. The old school has, a few years ago, placed it among the heart tonics belonging to the digitalis group, yet their experience with substitutes for digitalis has not encouraged many to try it in this field. Homœopaths admit its action upon the heart, nervous system, digestive tract and skin. The provings and poisonings do not, however, present a very reliable picture of its pathogenic influence in the latter sphere. In the *Cyclopædia of Drug Pathogenesy* there are no skin symptoms recorded. Allen, in his large work on *materia medica*, presents several provings where skin symptoms were noticed which were seemingly characteristic, though neither the doses nor the methods of administration are given. If these symptoms are reliable, then it must be a valuable remedy in a certain class of cutaneous eruptions.

In none of the toxicological works accessible can I find any reference to its action on the skin. In fact, but very little is to be found anywhere bearing on this point. It is said to be employed by the peasantry of the south of France as a topical measure in the treatment of skin diseases.

For the following interesting observation, I have to thank Dr. McAdoo, of Monroeville, O., who kindly took me to see the case.

Mrs. G., a woman of 88 years, German, in good health, the mother of fifteen children, and pregnant, within a few days of her expected confinement, picked off the wilted leaves from an oleander shrub which stood on the porch, and, without washing her hands, she scratched her chin. Within a few hours a spot upon her chin began to itch and burn, as well as to swell. Broad papules, covered with minute vesicles, soon commenced to form, with pronounced inclination to ooze and a tendency to coalesce. The eruption was of a pinkish-red appearance; the exudation seemed to be acrid and to set up further irritation

wherever it touched the surrounding healthy skin. In many ways it quite closely resembled the rash of *rhus* poisoning, yet this could be excluded, as she had not been out of the yard for weeks, and none of the vine was growing about the place.

The eruption gradually spread over the left, then over the right, cheek, neck, breast and finally over the lower limbs and the left arm. A crop of papules would first appear, then coalesce and the skin disintegrate to give way to a sogginess of the upper layer, with subcutaneous oedema and a subsequent oozing. The eyes were entirely swollen shut, so that it was absolutely impossible for her to open them, and the neck was also quite swollen. The ears were swollen, particularly the left one, which was thick, pinkish-red, as though it had been frozen, soggy-looking and twice its normal thickness. The eyes exuded a yellowish serum. All the time there was no discomfort except from the distress of the enormously swollen face, which prevented her from opening her eyes, and the torturing burning-itching of the skin, which no local applications, not excepting hot water, seemed to relieve.

All this time her temperature was not over a degree above normal, her pulse was generally 80 in the minute, though at the climax it rose to 95. No delirium nor restlessness.

In the course of a few days she passed through her confinement uneventfully, when the eruption vanished for nearly thirty-six hours, but it then again appeared and continued to increase. *Apis 8x* was administered without result, for the swelling of the neck gradually became so great as to interfere with swallowing, fluids, especially, being swallowed with difficulty. *Apis ♀*, ten drops in a half-glass of water, and of this a teaspoonful every hour, was then given, with benefit, for the next morning she was better, the oozing had decreased, thin yellowish scabs had formed which desquamated in fairly large flakes and the process had been gotten under control. She slept well during the whole course of the disease, her bowels moved regularly and only a slight thumping headache was complained of. On the extremities, the disease appeared and remained as scattered, round, reddish papules. In the course of a week she wholly recovered, without further complication.

That the eruption was due to the drug is quite certain, as it rapidly followed scratching with the poisoned fingers. Erysip-

elas would not have attacked the limbs as discrete papules, the temperature would have been higher, the constitutional disturbance would have been greater and chilliness or chills would have been experienced, which were wholly absent. It more resembled acute eczema, but that might be excluded by the rapid appearance of the symptoms after poisoning, their characteristicness of this remedy and their tractability.

Lilienthal (*Homœopathic Therapeutics*, 2d ed., p. 264) gives as characteristic indications for this drug, in eczema, "vesicular eruption about the head of children, with smooth shining surface, with drops of serum standing out here and there; humid scaly eruption upon the back of the head and behind the ears, with biting and itching, as from lice; skin gets raw from the rubbing of the clothing; gnawing itching while undressing; skin sensitive and sore." He also quotes it under "flavus," when there is "biting itching on the scalp, as from vermin; worse on the back part of the head and behind the ears; better when first scratching it, followed by burning and soreness; worse evenings, when undressing; humid, scaly, biting, itching eruption, especially on the back part of the head."

Dr. J. De Wée (*Journal Belge d'Homœopathie*, No. 2, vol. ii.) reports the case of a child of 2 years who had suffered from *crusta lactea* since the age of 9 months, and in whose case all various allopathic measures had been tried in vain. Behind its left ear, and extending into the hair and upon the cheek, there were vast crusts of a brownish-black color, which emitted a fetid odor and matted the hair together. On being detached, a vividly red and oozing surface would result. Oleander 12x was given, and in three weeks the crusts had fallen off, the oozing ceased and only a slight redness remained on the spot formerly affected. In another case of the same disease, in a boy of 5 years, seen in consultation, with the same localization which, according to Lilienthal (*l. c.*), is characteristic, oleander, in the same attenuation, had already, in a month, produced a notable amelioration of this obstinate disease.

From the accessible literature, no case can be found where such an intense action upon the skin has been reported. The plant not being a native of our country, opportunities for observation of poisonings are rare. From this observation it seemingly might be of value, homœopathically, in erysipelas or

acute eczema more especially, with pronounced local symptoms, with absence of corresponding constitutional involvement. The success of apis, in the tincture, as an antidote, after its failure in the third potency, is also a feature worthy of notice.

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### ANÆSTHESIA BY NÉBULIZED ETHER.\*

BY EDWARD S. GRIGSBY, M.D., PHILADELPHIA, PA.,

Anæsthetist to the Hahnemann Hospital.

(Read before the Homœopathic Medical Society of the County of Philadelphia, March 12, 1886.)

A SURGICAL discussion would hardly be complete without considering the subject of anæsthesia. Next to the surgeon in charge the position of trust and responsibility at an operation falls upon the anæsthetist. Indeed, it is a question whether his, summing up a year's work, is not the one of greater responsibility; for no matter how insignificant the operation demanding of the surgeon but little skill and absolutely no risk *per se*, yet, if requiring an anæsthetic, the patient must be subjected to all dangers, or nearly all, from the anæsthetic that would attend a capital operation. Statistics show the number of deaths due to the anæsthetic to be quite as great before the operation has commenced as after the initial step of the operator. Let no one, then, who is called upon to give an anæsthetic, however trivial the operation, forget that into his hands is placed the responsibility of guiding a life as close to the abyss of death as it can go and yet be recovered. Since the discovery of liquid anæsthetics the method of administration has been a subject of great importance, and, as a result, the methods of administration are numerous. Hardly a year passes that does not produce a new apparatus for giving ether. Generally speaking, methods are divided into "open" and "closed," the former best illustrated by the Allis inhaler, and the latter by the Clover inhaler, so popular in England.

I need hardly mention the fact that the first step necessary in the administration is the conversion of the liquid anæsthetic

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\* A preliminary paper.

into a gas or gaseous form, and that this must be done mechanically, or, in other words, the change is physical and not chemical. The simplest and most efficacious method of accomplishing this should be the ideal way of administering ether. Dr. W. T. G. Morton, who first publicly produced anæsthesia with ether for a surgical operation, employed a glass globe, fitting the face tightly, with a sponge saturated with ether at the top, and with two tubulous openings, one for the admission of fresh air and one for the escape of the expired air, both governed by valves. His patient was nearly asphyxiated, and a careful investigation at the close of the operation revealed the fact that the valve governing the admission of fresh air had failed to work; hence the asphyxiated condition of the patient. The failure in this case for a more or less complicated apparatus to work called at once for simplification and improvement. Since then, as before stated, the methods of giving ether have been numerous, running through all forms, from the simple towel cone to an elaborate apparatus requiring hot water to vaporize the ether, thence conveyed by a rubber tube into a rubber bag reservoir, and administered by means of complicated valves, etc.

For the physician who gives ether but once or twice a year the open method, by means of the Allis inhaler or the towel cone, is by far the simplest, most convenient and safest. For hospital work such a method as devised by Dr. Packard, of Boston, is the most complete, and certainly most nearly approaches the ideal. But for the surgeon, who must operate at a moment's notice in a private house, who may be called suddenly some miles into the country, where necessary articles are often wanting, let alone conveniences, there is yet a demand for an apparatus whereby anæsthesia may be produced quickly, economically, and, at the same time, with safety. An apparatus that does not require an expert to manipulate, I was about to say, but will refrain from that, for I certainly believe in the proposition advanced by Dr. MacEwen that an anæsthetist *must* be an expert, and should be licensed by law; at any rate, an apparatus not requiring the originator to successfully work it.

Taking Dr. Packard's method as the ideal, I have, with suggestions and assistance from others, been trying to work out

this problem of an economical, safe, easily portable, and uncomplicated apparatus for giving ether. Observing the completeness with which the Globe nebulizer converted solutions, whether alcoholic or oily, into a perfect nebula, I concluded it could be applied to the rapid conversion of ether into the proper gaseous form required for inhalation. The nebulizer does not create a spray; it forms a very fine vapor, easily carried through a tube to some form of mask for inhalation by the patient. So far my experiments have been with the mask used by Dr. Northrop with his chloroform and oxygen apparatus. While answering the experiments satisfactorily enough to convince me that nebulized ether was a success, yet, through criticisms, I have been forced to devise some other form of mask or inhaler. These criticisms have mainly been: 1. The patient is required to rebreathe too much carbonic acid gas, thus producing an unpleasant degree of cyanosis, though I am convinced of no danger; 2. The uncleanliness of all rubber inhalers, and inability to satisfactorily sterilize them.

To uphold my opinion that the rebreathing of the expired air, especially when freshened to a certain extent by compressing the rubber bulb of the nebulizer, is not of great danger to the patient, I will quote from Dr. Turnbull's work on anæsthesia, page 353, on the subject relating to the inhaler devised by Dr. Parkinson:

"The rebreathing of the ether-charged air, with a small atmospheric mixture, is the main point on which the superiority of the inhaler rests. That it is not in any sense a defect or danger, practical experience of several years has proved, and in support of the position I will quote three opinions:

"Pridgeon Teale, writing in the *British Medical Journal*, says: 'The patient breathes the same air over and over again, thereby economizing the heat of the air passages, economizing ether, and enhancing the effect of the ether by partial asphyxia.'

"Mr. Woodhouse Braine, Lecturer on Anæsthetics at Charing Cross Hospital, states that in using the inhaler he frequently removes the sponge, and maintains anæsthesia by allowing the patient to breathe into and from the rubber bag. He says: 'It may be urged against this method that the patient rebreathes the carbonic acid of his own expired air—and this is true; but

from the length of time I have employed this plan, and from never having seen any deleterious results from it, I do not attach any importance to the objection.'

"Mr. Ormsby, in reply to an inquiry, has kindly written : 'I believe that carbonic dioxide, in a diluted form, assists the ether as an anæsthetic, while the rebreathing of the vapor warms it, so that it is more readily tolerated by the patient.'"

Dr. Parkinson concludes by saying : "In my own experience, which has been extended and considerable, I have found no disadvantages arising from the alleged asphyxiation."

The ability, skill and experience of the men quoted is beyond question ; yet to overcome the objection cited and still have a simple apparatus, is certainly a desirable point to gain. The mechanism of Dr. Packard's apparatus in this respect is quite complete, but constantly exhausting the mouth-piece demands more aerated ether or fresh air, according to the patient's condition, and this necessitates his rubber bag reservoir, which detracts from the simplicity.

The second objection, regarding the uncleanliness and inability to properly sterilize any existing form of closed inhaler, needs no comment. They are all more or less dirty, and none of them can be satisfactorily sterilized.

I hoped to be able to present a cone to-night answering, in part, these criticisms ; but having been repeatedly disappointed by the instrument-maker, I can only show a rough working model, and, in consequence, can only theorize, for a practical application has been impossible.

The idea embodied is a silk bag, supported by a nose piece, and fitting closely about the face and under the chin. It is detachable, and each piece can then be sterilized independent of its fellow. The silk is durable, will permit of thorough sterilization, and should last a reasonable length of time. The nose piece, besides supporting the cone, contains an inlet for the anæsthetic, and also an inlet for air, governed by a sliding valve, this to be opened or closed by the anæsthetist, as the patient's condition may require. The silk bag is not absolutely air-tight, as can be readily demonstrated by forced expiration when closely applied to the face. Basing my theory on the law of diffusibility of gases, that a warm gas is more diffusible than a cold gas, is it unreasonable to claim that a

great part of the carbonic acid gas exhaled by the patient, hot from the lungs, is diffused through the meshes of the silk, while the ether vapor, fresh from the nebulizer, is entirely retained? The quantity of air exhaled at each expiration is but little greater than the quantity of nebulized ether forced in with each complete compression of the bulb; and if the expired air, by means of the greater diffusibility, does escape in part, the patient is only required to rebreathe a small proportion of the expired air, and this cannot be dangerous. By this partial elimination of one of the disadvantages, we have left the advantages of a closed cone, viz.: 1. The inspired ether vapor is somewhat warmed, thus preventing a constant chilling of the respiratory tract and lessening the irritation. 2. The economizing of the quantity used. 3. By confining the ether vapor, the disagreeable odor is prevented from penetrating the room, or, as is often the case, the whole house. Ether can be given in this way, and hardly detected by the odor left in the room.

It is also a belief on my part that the danger of administering it, in the presence of a light, will be greatly reduced, if not entirely done away with. The question of economy, both as to time and the quantity of ether used is an important one, and by this method, we are ahead of any statistics I have been able to find regarding the administration of ether. In cases already tried (43) in number, the results are as follows: Average time required for relaxation,  $5\frac{2}{3}$  minutes; average time of administration,  $34\frac{2}{3}$  minutes; average quantity used,  $2\frac{2}{3}\frac{3}{4}$ ; greatest period required to relax patient, 10 minutes; shortest period required to relax patient, 2 minutes.

The reaction as a rule is very quick, on an average, much quicker than from ether by the open method, and the sickness due to ether much reduced. There has been absolutely no shock in any of the cases reported, and no stimulation whatever required.

The strain on one hand, by constantly working the bulb, might arise in the form of an objection, but I have not found it so. The bulb is very light, easily compressed, and constant pressure, as the anæsthetic state progresses is not necessary, slight periods of relief being obtainable. The administration is begun very slowly, the merest trace of ether being desired, and

gradually as you find the patient will tolerate it, increase the quantity; a little experimenting with the tube before one's nostrils, will answer more satisfactorily this question, of, How fast at first? As anæsthesia progresses, the vapor is increased until complete relaxation is obtained, when it can be somewhat decreased. Great care, as to the exact condition of your patient must be exercised in the early stages, for a slight decrease in the flow of the nebulized ether and a few breaths of fresh air will greatly reduce the condition of anæsthesia, and inconvenience the operator. I believe a point in favor of this apparatus, is the fact that every bit of ether given is a voluntary act of the anæsthetist. There is no automatic flowing of the anæsthetic, every time the bulb is squeezed, the anæsthetist is warned that he is giving the anæsthetic, and that warning should be quite sufficient to keep him ever on the alert for contra-indications of its furtherance. I wish publicly to thank several of our hospital staff, who have been interested in this subject, for helpful suggestions, since beginning the experiment, and especially to thank Dr. Van Lennep, for valuable criticisms and for the opportunity on several occasions to administer it to his private patients, proving its applicability in that respect.

## ACUTE INSANITY: ITS MANAGEMENT AND TREATMENT.

BY C. F. SOUDER, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

THE physician who is called in to treat a violent and dangerous case of acute insanity finds himself in an unpleasant position, and one that requires quickness of thought and action, as delay may mean death to the patient or to the attendants. From my personal knowledge, three cases of acute mania have died from lack of nourishment, due to not knowing how to feed them when they refused to eat.

Insanity has a greater diversity of symptoms than any other disease, varying from the most miserable and wretched to the happiest and most exalted; from human perfection to perfect demons; from imbecility to the most active mental activity.

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To describe all of the different forms of acute insanity would require too long an article, so only the two most common will be mentioned, that of acute mania and acute melancholia, with a description of a typical case of each as came under my notice and care, whilst serving as one of the resident physicians at the Westborough Insane Hospital (homœopathic), Westborough, Mass. The remarks on the management and treatment will be general, and not applied to any one form.

Miss H., æt. 23, good physical condition, educated, refined, no hereditary predisposition and no known cause for attack; was admitted to the hospital suffering with acute mania. At the beginning of the attack, was fore-lady in a large store, and first caused suspicion of insanity by being impudent to her employers, climbing on top of the highest shelves in the store and sitting there, trying to drown her pet cat in the bath-tub, throwing a comb and brush out of the window at a gentleman passing by, and throwing her gold watch and chain down the water-closet. She was treated at home for a few days, but grew worse continually, so was brought to the hospital. For nearly three months it was necessary to keep her fastened in bed. During that time had delusions; illusions; was destructive; had nymphomania; although of medium size required three or four nurses to control her; made day and night hideous with her laughter and screaming; slept only a few minutes at a time; had no desire to see her relatives or friends; refused to eat so had to be fed nearly the entire time. The activity and rapidity of her thoughts were wonderful, reminding me of a locomotive at full speed; witty, treacherous, and always scheming to get free. When improvement began it was rapid and continuous; slept better, gained in weight and in a few weeks was pronounced cured. She afterwards said she remembered everything that occurred during the entire attack,—the pleasure she derived from and the irresistible desire to swear, to be destructive, to be stubborn, and to do everything she knew she ought not to do—but would rather die than go through another attack. Belladonna was given during the violent stage; then changed to hyoscyamus.

Miss W., æt. 21, music teacher; good physical condition, no hereditary predisposition, and no known cause for attack; became suddenly insane with acute melancholia and was brought

to the hospital a few days afterward. When admitted was suicidal and destructive, so had to be placed under restraint; refused to eat, as she said the food was poisoned, so had to be fed; slept very little day or night; kept continually rolling her head, rubbing her hands, and repeating in the most pathetic manner, "Minnie W. don't know anything that was ever written or printed in any book, newspaper or magazine that was ever published in this wide world." She soon began to improve and recovered in a short time.

Delusions of insanity vary from the most horrible forebodings of evil to the grandest and most sublime attainments. Some imagine they are being persecuted by their relatives and friends for stealing, arson or murder; or some one wants to get rid of them and to accomplish it put poison in their food, or are conspiring to kill them. Others think their soul is lost, that they are filled with snakes, have no heart, or are dead. Others have great knowledge, wealth and power; rule Heaven and Earth, are President of the United States, are the Lord and Saviour Jesus Christ.

Hallucinations, or hearing of voices, is very frequent. One young lady heard her father speaking to her from the mattress on which she was lying, and she immediately tore it all to pieces hunting for him. Others hear voices telling them to do some act, or not to eat. They generally do anything the voices tell them to do.

Illusions, or mistaken identity, is not so frequent. One lady never saw any strangers; every one was some relative or friend of hers, and would kiss all the lady visitors if not prevented from doing so.

Ladies of refinement often become the reverse when insane, becoming dangerous, destructive, disgusting and vulgar. As a rule, insane people are suspicious of every one, and are constantly listening to and watching everything that is said or done. If patients have delusions of persecutions, their actions will indicate those of fear; but if they are of power, they will give orders and if they are not carried out may attempt to enforce them. Their actions will always be in harmony with their delusions. Their strength and power of endurance seem almost incredible; often going weeks at a time without any sleep, and during the entire time keep moving their body, swearing,

singing and shouting as loud as they can. The majority of acute cases are suicidal, especially those with melancholia, and require constant attention to prevent them from making away with themselves.

No disease requires more care—studying the habits, temperament and individuality of the patient—to be able to manage and treat the case to obtain the best results. Patients who imagine they are going to be shot, assassinated, poisoned or some other horrible calamity is going to befall them, suffer the same torture as if it were true, and will plead with you, if they have confidence in you, to protect them. Such patients should be shown the same kindness and sympathy as if it were true. As soon as they have entire faith in your sincerity and friend-ship, by reasoning with them, after letting them see the horrible calamity they predicted did not happen, if they are not beyond recovery or improvement, they will finally be convinced there is some truth in your assertions that their fears are imaginary. Be honest and candid with them; don't deceive them by actions or words, as they are quick to detect deception, and if they will not trust the physician or attendants, their usefulness is greatly diminished, and most likely they will never regain the patient's confidence.

Every one has heard the saying, "Insane people generally hate those they formerly loved." Why? As a rule, insane people accuse those who are brought in contact with them the most as being the cause of their troubles; and when they see their relatives and friends deceiving them and acting strangely towards them, their delusions are more firmly fixed, and reasonably so.

The majority of the insane can be easily managed by kindness, and no one appreciates kindness and sympathy more. Patients who are well enough to take interest in the surroundings will be greatly improved by having their minds occupied by ordinary work, cheerful reading, music, drawing, driving, games of all kinds, or anything that will excite their interest. One patient, who was so violent that it was necessary to keep him under restraint part of the time, became rational, as if by magic, as soon as he was allowed to play base-ball. Those who are destructive, uncontrollable, violent or dangerous can be managed by putting their hands in muffs, or by putting on a

strait-jacket, crossing the arms in front and tying the sleeves in the back, then tying the patient to some stationary object or chair; or, if it is necessary to keep them in bed, put on a canvasole, which can be done as follows: Make a strait-jacket out of strong canvas, with long endless sleeves which extend beyond the hands; have it laced or buttoned in the back. To the front of the jacket sew another piece of canvas, size and shape of the bed, making an opening for the head; then sew strings every few inches to all sides of the sheet part; also to the ends of the sleeves, to tie to the bed. Place the patient on his back, arms extended straight out; tie the sleeves to the sides of the bed, then the sheet to the sides and ends. A patient in this position enjoys some freedom, but cannot injure himself or others.

Insane patients need a large amount of food, but do not require the same care in the selection as most diseases do. Those who cannot be induced to eat can be readily fed by running an ordinary 18-inch soft flexible catheter tube, sizes 12-18, through the nose, first moistening the end, following the back of the throat into the oesophagus, then stomach, and attaching the free end to an ordinary household syringe. They will resist at first, but will soon become quiet, unless it is in the trachea, in which case they will struggle, cough and become purple in the face till it is withdrawn. It is safest to wait till the patient is quiet before attempting to pump the food into the stomach, and then do it slowly. When the tube is used, only liquid food can be given, which generally consists of one quart of milk, with one or two eggs beaten up in it and a pinch of salt, broths, soups and beef tea. When the patient will not take the medicine, put it in the milk.

The earlier the treatment, the more favorable the results. Mild cases, as a rule, do not receive treatment till the disease has become chronic, or until it is too late to get the best results. It is my belief if greater care were taken to find the cause of the attack and its removal if possible, there would be more permanent recoveries. A large percentage of the cases admitted to the asylums give no cause for the attack, or if one is given it is too trifling to be seriously considered. The gentleman who brought the case of acute mania, when asked for the cause of the attack, answered: "Don't know, but think it's because she

had no beau." As a rule, the more rapid the onset and the more violent the attack, the shorter and more favorable, providing the patient does not die from exhaustion, and very few do when properly treated.

To give an idea of the prognosis, statistics from the Middletown Asylum (homœopathic), as given by Dr. George Allen, are quoted :

"From 1874 to 1892, 3629 patients treated ; 2775 discharged; 1352 recovered. Of those who came under treatment during the first six months of disease, over 53 per cent. recovered, while still earlier hospital treatment gives still better results ; and that 76 per cent. of those who recovered did so in less than one year, while 48 per cent. of the number recovered in less than six months.

"Acute melancholia (most numerous), 907 cases, 56 per cent. recovered.

"Acute mania (second in numbers), 69 per cent. recovered.

"Puerperal insanity, 39 cases, 27 recovered."

Such remedies as bell., acon., gel., hyos., stram., nux vom., ignatia, phosphoric acid, phosphorus, lachesis, anacardium are frequently indicated, but no morphia or narcotics were given to produce sleep.

The most favorable signs are when the patient improves in mind and gains in weight at the same time, and when the delusions are changeable. Unfavorable, when the delusions are the same for a long time, and when there is an increase in weight without improvement of the mind. As long as the patient remains in poor physical condition there is little hope for improvement.

Most patients can best be treated at an insane hospital or asylum, as the physicians and nurses have had experience, and have all the necessary paraphernalia for the proper management of the case ; besides, most patients who are destructive or uncontrollable at home, become quiet and easily managed when placed in a hospital. It is to be earnestly hoped we will have an institution of our own within a few years, where our unfortunate relatives and patients can receive homœopathic treatment.

## GLAUCOMA.

BY WILLIAM SPENCER, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

THIS subject has been selected, not with the intention of offering anything new in the ætiology, pathology or treatment, but because I feel that this disease is so disastrous and the damage so irreparable that the symptoms and a picture of it should be familiar to all of us.

Glaucoma is not a new disease; the inflammatory variety has been known from antiquity. The non-inflammatory having no external changes, can only be diagnosticated by making an ophthalmoscopic examination, and therefore must date from or after the discovery and use of the ophthalmoscope. The essence of glaucoma lies in the increase in the intraocular pressure, from which all the other essential symptoms can be deduced.

The first to recognize the increase in tension as the most important symptom was Mackenzie, in 1830; later, Von Graefe.

The ophthalmoscope, discovered by Helmholtz in 1851, opened up a new method of examination. Heretofore, the exact pathological changes were not accurately known. The inflammatory variety was regarded as having connection with gout, and was hence called ophthalmia arthritica. The blindness of the non-inflammatory variety has been "lumped" together with other kinds of blindness under the common name of that almost obsolete word, amaurosis. Heinrich Müller, in 1856, demonstrated anatomically the pressure excavation of the optic nerve. Soon afterwards, Weber and Förster diagnosed it accurately in the ophthalmoscopic picture.

The following subdivisions of the disease are recognized: primary or secondary. The primary may be with inflammation. This may be acute, subacute and chronic, or "an advanced stage of the non-inflammatory," hæmorrhagic and fulminans. By the secondary is meant increased tension, consecutive to some other disease.

Glaucoma sets in with varying symptoms. If the pressure

rises suddenly to a considerable height, inflammatory symptoms are excited, and we have to deal with an acute or inflammatory glaucoma. On the contrary, if the increase in tension comes on gradually and does not become intense, we have a non-inflammatory condition, or glaucoma simplex. I will speak of it as inflammatory and non-inflammatory, without going into the subdivisions.

Inflammatory glaucoma runs a typical course, especially in acute cases. I will quote Fuch in giving the different stages, with the leading symptoms.

First stage of prodromal.

Second stage—attack of acute glaucoma.

Third stage—that of glaucoma absolutum.

The prodromal stage, which in most cases precedes the inflammatory attack, is characterized, first of all, by attacks of obscuration of vision; complains of a cloud or smoke concealing objects from him; lights are seen as if encircled with a ring, having the colors of the rainbow; the eye feels tense, or there is a dull frontal headache; on inspection, the cornea appears dull and clouded, like glass that has been breathed upon; the anterior chamber somewhat shallower through advancement of the iris; the pupil is dilated and reacts sluggishly; the tension of the eye is increased; frequently, too, slight ciliary injection is present.

Such an attack ordinarily lasts several hours, after which the eye returns to the normal condition, both as regards its appearance and as regards its function. The attacks at first make their appearance at long intervals (of months or weeks); later, they become more frequent. Often specific causes for their existence can be demonstrated, such as hearty meals, lateness in going to bed, causes of emotional excitement (card playing, etc.). If the attacks come on in the evening, they always cease when the patient falls asleep; even in the daytime an attack may be cut short by his going to sleep.

In the interval between the prodromal attacks the sight is normal, but stronger and stronger glasses have to be employed for reading; a rapid increase of presbyopia through diminution of the power of accommodation. The prodromal stage lasts only a few weeks, or may be protracted over months or even years. The eye acquires externally the glaucomatous aspect,

and an excavation of the nerve forms in consequence of the oft-repeated increase of pressure. Consequently, the sight is no longer perfect.

The second stage of acute glaucoma, sets in suddenly, after the prodromal stage has lasted a longer or shorter time. The chief causes of an acute attack, are states of congestion of the venous system, especially those due to enfeeblement of the heart's action. Also mental emotions, particularly of a depressing character, and dilatation of the pupils. A drop of atropine in an eye which is predisposed to glaucoma may excite an attack. This danger, Dr. C. M. Thomas tries to guard against, by warning his students never to use atropine in an eye with a dilated pupil.

The symptoms of the acute attack are the same as those belonging to the prodromal attack, except that they are more pronounced and are accompanied by inflammatory phenomena (injection, œdema of the lids and conjunctiva, and pain). The pain is violent, radiating from the eye along the first and second branches of the trigeminus. The patient complains of pain in the head, the ears and the teeth. Simultaneously with the pain the visual power falls rapidly away, so that only large objects are seen.

The field of vision is contracted, mostly on the nasal side.

The cornea has a pronounced smoky cloudiness and is almost or quite insensitive to touch. The tension is considerably elevated and remains permanently so. Ophthalmoscopic examination is impossible, on account of the marked cloudiness of the cornea.

When the cornea clears the examination shows at the optic nerve entrance the signs of the general hyperæmia. The excavation of the optic nerve is not present directly after the attack, because for its formation a long period of increased tension is required. Cases which have had a long prodroma show it after an acute attack.

After some days or weeks there is a subsidence of the acute symptoms and the patient gives himself up to the hope that he is permanently cured.

Then a new attack sets in. This, as far as inflammatory symptoms and pain are concerned, is usually less intense than the first, but results in a still further reduction of the sight.

These attacks follow each other at longer or shorter intervals; the sight at length becomes entirely extinct.

The disease has then entered upon the third stage, that of glaucoma absolutum. The eye is completely blind, and presents the following picture. The distended anterior ciliary veins which unite around the cornea forming a bluish-red circle of dilated vessels. The cornea is shining and transparent, but insensitive; the anterior chamber is very shallow.

The iris is reduced to a narrow gray marginal band, and the pupillary margin is encircled by a broad black border. The dilated and rigid pupil is greenish or of a dirty gray. The lens is cloudy (cataractous). The optic disk is deeply excavated and the eye is as hard as stone. Later on, degenerative changes make their appearance in the blinded eye; the final outcome is usually atrophy of the eyeball. After the eye has been hard for years it at length becomes softer, small and atrophic. In other cases, abscess of the cornea develops with perforation and consecutive irido-cyclitis, or even panophthalmitis, together with phthisis bulbi. Not till the glaucomatous eye has become shrivelled does it allow its unfortunate possessor to have any lasting rest.

In the non-inflammatory or glaucoma simplex the increase of tension sets in very gradually. The eye looks quite normal externally, or it gives evidence of the lesion by the greater prominence of the distended anterior ciliary veins, and also through the dilated and sluggish pupil. The tension is slightly increased; often this is not detected on first examination. Some cases of simple glaucoma in which the tension is never found distinctly increased. Not having any marked external symptoms, and sometimes, indeed, any manifest increase of tension, we are thrown back upon the ophthalmoscopic examination for the diagnosis.

Such an examination shows a total excavation of the optic nerve, the depth of which corresponds to the duration of the disease.

The subjective symptoms, since the inflammatory attacks and the pain are wanting, consist almost exclusively of the disturbance of vision. The field of vision is contracted, there is a diminution of central vision acuity. The latter develops late, when the field of vision has become very small, patients are

still in condition to read, while they are scarcely able to go about alone. The reduction of vision takes place very slowly and gradually, so that the patient himself does not become aware of the existence of his disease until late.

Glaucoma simplex, not infrequently changes into inflammatory glaucoma. It always attacks both eyes, and sometimes occurs in young people in contra-distinction to inflammatory glaucoma.

Inflammatory glaucoma almost always attacks both eyes. They are rarely affected at the same time. The disease in the second eye follows months or years after the first. It is a disease of advanced life, fiftieth to seventieth year, occurring in women more than men. In some cases heredity is distinctly influential. Hyperopic eyes are most frequently affected; about two-thirds of the whole, while myopia gives about one-fifth of the whole.

Neuralgia of the fifth nerve sometimes is a cause. Rigidity of the vessel walls (arterio-sclerosis), habitual constipation and premature cessation of the menses predispose to glaucoma. It occurs more frequently among the Jews than the Christians.

There are many theories advanced to explain the cause of the intraocular tension. Whether it is dependent upon either a hypersecretion or diminished absorption ought to be a question having considerable weight in the selection of our remedy if we expect to make a cure according to the law of similia. The secretion of the aqueous humor is almost wholly from the uveal tract (*i.e.*, iris, ciliary body and choroid). Absorption of the intraocular fluids takes place through the filtration passages in the sclera, near the border of the cornea (the lymph passages and canal of Schlemm). Any disturbance, therefore, in the equilibrium between secretion and absorption will of course cause a change in tension.

As causes of hypersecretion, we may mention irritation of the trigeminus nerve and serous inflammation of the uveal tract. Especially is this true if the secretion is more in the vitreous humor than in the aqueous, for the lens and iris are thereby advanced, thus narrowing the iritic angle and interfering with absorption. A predisposition to hindrance in absorption is found in unusual rigidity of the sclera, which may be more marked in one race than in another, or in one family than another, and it is always found in old age.

Also the filtration passages may be closed by any localized inflammation of the sclera or the iris, which causes an adhesion of the periphery of the iris to the cornea or sclera.

Swelling of the ciliary processes will press forward the periphery of the iris. An increased diameter of the lens will narrow the space between the lens and the ciliary processes through which the nutrient fluids pass, by osmosis, from the vitreous to aqueous, and then out through the filtration passages. This would cause increased tension in the vitreous over the aqueous, thus causing an advance of the iris and lens. It therefore appears that there is no one cause for glaucoma, but that several elements enter into the *aetiology*.

#### TREATMENT.

Glaucoma passed for an incurable disease until Von Graefé discovered the curative action of iridectomy. Other operations have been devised, such as sclerotomy, paracentesis cornea, myotomy, etc., but none have been able to displace iridectomy. As regards the time for performing the operation, it is always best to operate as early as possible. In the prodromal stage some favorable results may be obtained from internal medication. By the use of the indicated remedy or the instillation into the eye of a myotic (eserine or pilocarpine), an operation may be postponed. In an acute attack of glaucoma it is very difficult to decide how long we can safely delay operating, bearing in mind that a high degree of increased tension may permanently destroy vision within a few hours.

It is, therefore, not only unwise but reprehensible in any physician to delay the operation when there is danger of permanent injury to the eye.

The myotics, eserine and pilocarpine, are powerful agents in combating increase in tension. They act only when the iris is capable of contracting satisfactorily. Unfortunately, the effect of myotics upon ocular tension is not lasting; therefore, they cannot cure glaucoma permanently, and thus dispense with iridectomy.

The other methods of medicinal treatment, which formerly were very numerous, are now obsolete—so say our friends of the dominant school; but with us we have a number of remedies that have been tried and found most efficacious in relieving

the severe neuralgic pains, as well as having a direct action in relieving the increased tension. We should think of acon., bell., cedron, colocyn., prunus spin. and spigelia for ciliary neuralgia; cedron and bryon. for supraorbital neuralgia; bryon. and gelsem. for hypersecretion; phos., gels., kali iod. and sul. for clearing up media after the subsidence of an attack. Every case should have our careful study, and the remedy selected according to the totality of symptoms present.

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### PROSTATIC HYPERSTROPHY.

BY H. L. NORTHRUP, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

In other words, the bane of old age. Physiologically, the prostate is a sexual organ. Its intimate association with the sexual apparatus is explained by its anatomy, for it is a musculo-glandular body embracing a part of the ejaculatory ducts, and traversed by a portion of the urethra which contains the orifices, or outlets, of these ducts. The muscular element, of the involuntary variety, prevents the regurgitation of the seminal fluid into the bladder. During its ejaculation the glandular structure forms a secretion (the prostatic fluid) which mingles with, dilutes, and gives bulk to the semen. The prostate is placed at the neck of the bladder, the mucous membrane of the latter covering its upper posterior portion. It surrounds the outlet of the bladder and encloses the prostatic urethra.

Prostatic hypertrophy is a disease of the second half of life, and may exist for an indefinite time without causing any symptoms. Sooner or later, however, the well-known list of vesical irritation, getting up at night to urinate, dull pains in perineum and urethra, catarrh of the bladder, retention, etc., will be presented to the patient and to his medical adviser.

How does prostatic hypertrophy cause these symptoms? By forming a dam at the neck of the bladder through the bulging of the prostate into the bladder cavity, and the consequent elevation of the vesico-urethral orifice; by distorting the pros-

tatic portion of the urethra and lessening its calibre. Because of this dam the bladder cannot completely empty itself, and the "residual" urine decomposes and literally infects the bladder wall. Hence the beginning cystitis, which becomes aggravated later and may be followed by septic inflammation of the whole urinary tract. The walls of the bladder increase in thickness; diverticula, or elevated bands in the mucous membrane develop.

With the symptoms already noted a diagnosis is easy. Let the examiner confirm his subjectively formed opinion, however, by inserting his finger into the rectum and palpating the prostate through the anterior rectal wall, noting any increase in size and firmness. Let him ask his patient to pass all the urine he can naturally, and then introducing a soft clean catheter, ascertain if there is any residual urine present. This found, he has additional proof of hypertrophy of the prostate.

This hypertrophy may be complicated by some malignant growth, or by tuberculosis of the prostate. A calculus frequently develops in the residual urine, and adds its characteristic symptoms to those of the hypertrophy.

I need not state the prognosis of this trouble, for its indefinite, interminable course, its undermining of the general health through suffering and instrumentation, the poor results accompanying palliative and the old forms of operative treatment, are well known to all.

In regard to treatment, if the case is seen at an early stage and before the worst symptoms have appeared, the first thing necessary is to teach the patient to use a clean flexible catheter one or more times daily, and particularly just before retiring at night. The object of this is to remove the residual urine.

When the case has advanced and septic inflammation, or purulent catarrh of the genito-urinary mucous membrane is present, to the removal of the residual urine must be added the injection of some antiseptic, such as boroglyceride, trichloride of iodine, bichloride of mercury, etc., that the bladder may be cleansed and antisepticised. Boroglyceride and trichloride of iodine, particularly the latter, are the most valuable, and have answered well in relieving the symptoms and in limiting complications.

A common operative procedure is to establish permanent

drainage of the bladder by means of a suprapubic or perineal fistula. The former is preferred, though neither one gives the results desired.

Prostatectomy (excision of more or less of the prostate) has been performed, *via* the suprapubic, perineal, or urethral routes, and while regarded as "good surgery" by some, is looked upon as irrational by others. Considering it from my own standpoint, it is not a very acceptable operation.

It is now known that castration causes a diminution in the size of the prostate, just as oöphorectomy brings about atrophy of the uterus. The prostate, anatomically speaking, is the homologue of the uterus, *i.e.*, it is the male uterus.

After experiments upon animals, followed by castration of man, it was found that the prostate diminished in size within a few days or weeks, the severity of the symptoms subsiding with the decrease in the size of the gland.

The operation of castration is a very simple one and not attended by any special risk. Even a simpler substitute yet has been recently suggested and practiced, and good results claimed. I refer to ligature of the vas deferens. With that I have had no experience; with castration, enough to convince me of its value. From a list of several cases permit me to quote the following:

Mr. —, 68 years, suffered (and I use the word with its full meaning) from enlarged prostate. His family physician, Dr. T. L. Chase, improved matters by using boroglyceride injections. One night, however, retention occurred, and I was called to catheterize him, which I did not succeed in doing. After prolonged, careful attempts to introduce the catheter I was obliged to aspirate the bladder, which extended to the level of the umbilicus, through the hypogastrium. One week later retention again occurred, and we decided to open the bladder above the pubes. Before doing so I explained to my patient his future as far as the bladder and prostate were concerned, described the effect of castration, and advised suprapubic cystotomy to bring about immediate relief of retention and dysuria and castration to cause atrophy of the prostate that my patient's past history might not repeat itself.

My record book says, under date of March 31, 1895: "Has not urinated for nearly 24 hours. Catheterization ineffectual.

Advised epicystotomy and double castration. Explained operations and effects to patient, who consented to both operations. Ether, Dr. B., assistant, Dr. Chase. Usual preparations, median incision over bladder, control suture of bladder wall and incision through latter. Examination of the bladder shows practically normal muscular and mucous coats, with, however, considerable overdistension; an immense enlargement of the nodule lobe of the prostate. Stitched opening in bladder to parietal peritonæum and packed lightly with iodoform gauze. Iodoform gauze and sublimated gauze, cotton and adhesive plaster dressings. Incisions into each scrotal sac, ligation of spermatic cords close to external abdominal rings, with heavy chromicized, carbolic-water catgut, removal of testicles, catgut suture of both wounds. Iodoform gauze dressings, to be changed as soon as wet with urine. Carbolic-water catgut sutures."

This patient made a perfect recovery without "let or hindrance." In three weeks I examined his prostate per rectum, and I know it was considerably reduced in size. This man's suprapubic fistula has healed completely. He passes urine naturally in every way, and he weighs 25 or 30 pounds more than he ever did.

I mention this case because of the satisfactory results of the castration upon the hypertrophy of the prostate and because of the triple character of the operation.

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#### POST-PARTUM HÆMORRHAGE.

BY J. M. CALEY, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

NOTWITHSTANDING the large amount of valuable literature written upon this subject, both in medical journals and textbooks, the subject is an ever new and interesting one. If the writer can present a few thoughts upon the importance of watchfulness on the part of the attending physician and warn him to be ever on the alert for this serious complication, he will feel that his object is achieved. It is at the end of the third

stage of labor, that the utmost vigilance is required, however simple the labor may have been up to this time. It is in the apparently normal cases that the catastrophe often occurs and the physician is thus taken unawares. The mother is brought to the brink of the grave in a few seconds, and the house of joy is suddenly changed into one of sadness. The unprepared physician, standing by without the means at hand to stay the life-current, certainly cannot pass uncensured for his neglect. The history of previous uncomplicated cases, is no criterion and excuse on that ground cannot be tolerated. Yet, with all that has been written upon the importance of being fully prepared for emergencies, complete neglect of the necessary precautions is frequently met.

It can be put down as a general rule, that to treat disease successfully, the physician must be thoroughly acquainted with the parts involved. In post-partum hæmorrhage, however, common sense may often take the place of technical knowledge. When the placenta becomes detached from the uterine walls, in normal cases, the contraction of the muscular fibres of the uterus reduces the calibre of the uterine sinuses which had carried blood for the foetal nourishment and thus hæmorrhage is to a great extent avoided. If by some unlucky chance, the uterus does not contract properly or pieces of partly detached placenta remain, the mouths of the vessels continue open and hæmorrhage, moderate or severe, results, according to the calibre and number of the sinuses involved. The question is now a mechanical one. Produce contraction or remove the partly detached pieces of placenta, as the case may be, and our object is accomplished. The most frequent cause of post-partum hæmorrhage is imperfect contraction of the uterus. This is often due to rapid delivery, either naturally or with forceps. Also, to over-distension of the organ, as in case of twins or an abnormal amount of amniotic fluid. In prolonged labor, the walls become weak due to their thinning from over-distension and the contractile power is thereby lost. Often, the mother's health is found to be impaired. This may arise from various causes. In consequence of her being in this reduced condition, the uterine contractions would naturally be imperfect and here is where the physician must come to the rescue. In order to be provided for such emergencies he should have a special

obstetrical bag which should be always filled and ready; otherwise, some important article might be readily overlooked. Especially is this apt to be the case when the call comes at night. In addition to the articles necessary for the previous stages of labor, it is advisable, we might say imperative, to have such necessary articles as the hypodermic syringe, fountain syringe, cotton tampons, ergot, brandy, alum, an infusion outfit, and of course, the case of homœopathic remedies. These, together with what can be obtained at the home of the patient—vinegar, ice, hot and cold water, will provide the physician with all that is necessary to meet any emergency that may arise in the third stage of labor.

If upon the removal of the placenta, a hæmorrhage should occur, and the Credé method should fail to produce the proper contraction and the flow continue, the hypodermic injection of a non-alcoholic preparation of secale, either into the thigh or abdominal wall, would be the next wisest step to take in order to arouse the sleeping or exhausted uterus to fresh exertion. Although ergot does not hold as important a place in obstetrics among the homœopathic fraternity as among the allopathic, yet we have at present, no remedy in our pharmacopœia more effective or one on which so full dependence can be placed. It whips up the relaxed muscular fibres of the uterus to contraction in a way no other drug can. Its effect, too, is generally more lasting than that of other methods to be mentioned. Much has been said, of late, against ergot, but I have obtained very good results from its use. When pieces of adherent placenta are suspected or the cavity is filled with clots, insert one hand into the uterus, grasp the organ firmly from without, and empty the cavity quickly. In some cases it may be necessary to go further, in order to stop the bleeding. Swabbing the cavity of the uterus with vinegar is often a very effectual method highly recommended by prominent obstetricians. Small pieces of ice inserted into the uterine cavity is also a good method of stopping hæmorrhage, and may be held less objectionable than vinegar on the ground that there is less likelihood of carrying infection into the system. Let this be as it may, both remedies have rendered valuable services in many cases.

If from any cause the loss of blood is considerable, gravity

may assist in saving life. Removal of the pillow from under the head, elevation of the foot of the bed and the constriction of the circulation of the extremities for a time play an important rôle. Last, but not least, of the measures to be resorted to is infusion. This procedure has recently assumed an important place in general surgery, especially since a saline injection has been found as efficacious as the older method of transfusion and far easier of accomplishment. What applies to general surgery applies equally to obstetrics in cases of post-partum hæmorrhage. The writer ventures to predict that in the near future the infusion apparatus will be found in every well-regulated obstetrical bag. So far, only the methods of stopping the hæmorrhage after its actual occurrence have been mentioned. The means of preventing a post-partum hæmorrhage are as important as the former—far more so if we were always able to foretell the oncoming misfortune. The indicated homœopathic remedy—that one agreeing closest with the totality of symptoms of the patient—holds as good here as in any other case the physician is called on to treat. That the homœopathic remedy has prevented thousands of cases of hæmorrhage there is little doubt. To give a thoroughly indicated homœopathic remedy at the end of the second stage of labor, as a safeguard against hæmorrhage in suspicious cases, is, no doubt, good practice, as the medicine will have a few minutes to act before the beginning of the third stage. But when the profuse flow has actually begun, it would seem too long to wait for internal medication to act, especially if the hæmorrhage is severe.

Among the long list of remedies employed for uterine hæmorrhage, the following hold a prominent place: *Trillium pend.*, *arnica*, *belladonna*, *caulophyllum*, *china*, *ipecac*, *hamamelis*, *secale*, *sabina*, *millefolium*, *erigeron*, *carbo veg.*

*Trillium pend* has profuse hæmorrhage, prostration, vertigo, palpitation, a sense of sinking at the pit of the stomach—suitable to women who always flood after labor.

*Arnica* in cases where the hæmorrhage is caused by shock or injury—a good remedy also to relieve the soreness and bruised condition of the parts.

*Belladonna*, profuse flow of bright-red blood; hot; pressing down feeling, as though everything would escape through vulva; backache.

*Caulophyllum*.—Hæmorrhage due to too hasty labor; flow profuse; lack of tonicity; walls of uterus relaxed and flabby.

*China*.—Hæmorrhage from uterine atony; cold skin; ringing in ears; loss of sight; fainting.

*Ipecac*.—Flow of bright-red blood, cutting pains about umbilicus; nausea and vomiting.

*Secale* is best adapted to thin, scrawny women. The hæmorrhage is passive; there is tingling in the upper and lower extremities. Although the surface of the body is cold, the patient insists on being uncovered.

*Erigeron* has profuse hæmorrhage associated with irritation of the bladder and rectum.

*Carbo veg.* is indicated when there is a continuous passive flow; the patient wants to be fanned; the skin cold and bluish; the pulse weak and rapid.

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**TUMORS OF THE GROIN SIMULATING INCARCERATED HERNIA.**—Behr calls attention to a number of conditions which may closely simulate an incarcerated inguinal hernia, and give rise to much perplexity. They are—hæmatoma of the spermatic cord, or of the vulva, rotation of testicle on its axis, suppuration in an old hernial sac, inflammation of an undescended testicle, acute hydrocele of the cord, and acute non-suppurating adenitis.

Hæmatoma of the spermatic cord in men is far from rare, and is always due to direct traumatism to the groin; sometimes, even after cough or an effort, it may occur. In women, in the last months of pregnancy an acute hæmatoma of the vulva may appear. Ecchymosis of the skin is here characteristic, though it may be absent if from direct trauma. Though if it set in suddenly, and be accompanied by vomiting, the latter is not persistent, obstinate, or continuous, and the tumor is not tympanitic on percussion. Axial rotation of the testicle greatly resembles an incarcerated hernia, but the percussion sound is not tympanitic. The vomiting may even be stercoraceous.

Suppuration of an old hernial sac will not give an expansive impulse on coughing; the tumor is dull on percussion, edematous, red, and very tense to the touch.

Inflammation of an undescended testicle is sometimes met with in young subjects, especially from trauma or gonorrhœa, and the symptoms may simulate an incarcerated hernia. The pain is very violent, and more intense than in hernia; the tumor does not give an impulse on coughing; the percussion sound is dull, and the abdomen is not distended; the absence of one testicle will clear up the diagnosis.

Acute hydrocele of the cord is a rare disease, and beyond vomiting and obstinate constipation, the other symptoms are but little characteristic of hernia. The dulness to percussion and the feel of liquid on palpation are differential signs.

Acute, non suppurative adenitis may be very difficult of diagnosis, especially where signs of local irritation are lacking. The writer observed a case in a child of six months (male), where a globular tumor rapidly formed, in two days, in the right femoral region, but without the overlying skin becoming red or irritated. The tumor was tense, hard and irreducible, with no stool for two days. A diagnosis of incarcerated hernia being made, an operation revealed the swelling to be an inflamed gland situated above the saphenous opening.—*Il Progresso Medico*.

## CORRESPONDENCE.

### THE INTERNATIONAL HOMOEOPATHIC CONGRESS, 1896.

To THE EDITORS OF THE HAHNEMANNIAN MONTHLY :

*Gentlemen.*—I have been very sorry to read the criticism in your current number upon our “Preliminary Announcement.” As it is largely based on misunderstandings, I trust you will allow me space in your next issue for a few words of explanation.

1. You take exception to the appointment of Englishmen to every office of the Congress. You forget that herein we are only following the precedents of 1876 and 1881,\* where the working staff was composed exclusively of physicians of the country in which the meeting was to be held—for the obvious reason that they alone would be at hand for its organization and preparation. Now, as then, it is expressly provided that the Congress is free “to elect Honorary Vice-Presidents from those foreign guests and others whom it desires to honor.”

2. You ask (not too kindly) who is to “accept” the essays, to make the “analyses,” and to “appoint” the openers. The analyses, being given from the chair, will have to be made by the chairman (*i.e.*, the President or the Vice-President); but I doubt not that if any author preferred to make his own *précis*, that officer would gladly accept it in lieu of one of his own. The acceptance of the essays sent in would naturally belong to the organizing body which had solicited them; on the present occasion, however, the American Committee † having under-

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\* These were bad precedents to follow, especially when there were better ones.

† This committee was appointed on the suggestion of the President in his Business Address, that a committee be appointed to secure a large attendance of American members at the “I. H. C.,” their special work being to “arrange transportation and business details in relation to this subject.” All reports emanating from this committee received to date have been strictly in this line. There is nothing to indicate that they have assumed other and more extended prerogatives which a more liberal interpretation of the report of the “Committee on the President’s Address” which was adopted would entitle them to. “We recommend the appointment of a committee of five to make arrangements for the International Congress to be held in London in 1894.” If this committee has taken part in planning the organization of the Centennial Celebration of Homœopathy which is indissolubly linked with the Sixth Quinquennial International Congress of Homœopathic Physicians, then they have grievously misrepresented the American idea.

taken to collect contributions from its fellow-countrymen, we have—at its desire—left in its hands the final adjudgment upon the papers so obtained. We have also asked it to appoint openers on the three subjects we have placed at its disposal; and while we bear for ourselves the burden of providing the others, our colleagues may be assured (they ought hardly need assurance) that no distinctions of nationality will bar us from making the most suitable choice.

3. Your unfavorable judgment upon our programme needs modification by knowledge of the facts of the case. In the summer of 1894 a circular letter—enclosing the announcement and rules of the approaching Congress, and asking for promises of papers for discussion—was sent to all the representatives of homœopathy throughout the world, and was published in your pages. When the Committee of Arrangements met in June, 1895, it appeared, that while several essays had been offered by British and Continental physicians, only one response of the kind had come from America.\* It was determined that personal applications should be made in suitable quarters there. Before this could be done, however, a communication was received from the committee upon the International Congress appointed by the President of the American Institute of Homœopathy at its Newport meeting, offering to undertake the task of collecting essays† in its own country.‡ This proposal was accepted; but up to January last, when we prepared our “Preliminary Announcement” (and indeed up to the present time of writing), no result had been reported to us. We had, consequently, to construct our programme from the material available to us, and all we could do for America was to leave three places vacant (out of the possible nine) for that country to fill up. For this reason, also, the United States were not mentioned among the countries for which we had been promised, or now solicited,

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\* Presuming, “was sent to all representatives of homœopathy,” means journals and not individuals, it is hardly necessary to say that an American physician would not seriously consider a request given in such a manner. If individuals is meant then the “Committee of Arrangements” was unfortunate in its selection, and should have sought the advice of those in a position to have rightly directed them.

† See its *Transactions*, pp. 162, and xx.

‡ The President of the “A. I. H.” has not even had the courtesy of a request for an essay or communication extended to him up to date, April 20, 1896.

reports. The American Committee had undertaken to obtain such report in their case; we could neither acknowledge it nor ask for it. Surely you could not think that we should desire to receive reports on homœopathy from the rest of the world and omit the United States! That would, indeed, be performing "Hamlet" with Hamlet left out.

4. But while giving us no credit for what we are waiting for, I hardly think you have done justice to what we have already in hand. You have omitted mention of two of our subjects\*—the treatment of strumous ophthalmia and that of deafness; and in quoting (rather sarcastically) our statement that we have no further need of individual papers, you do not give the reason we assign therefor. Our object is to provide suitable subjects† and material for *discussions*, and to give to these the whole time of the Congress, conceiving it to be for such interchange of thought and experience that we come together on such occasions. Our afternoon general meetings—the first being devoted to the President's Address, and the general considerations growing out of it, give us only nine hours for discussion, and we can only expect to do justice to as many subjects—which now, *in esse* or *in posse*, are already provided. This is why we said that we did not *need* further papers. If, however, any one should yet seek a hearing, it may be possible to find an opportunity for him at one of the sectional gatherings in the forenoon. These were intended to be gotten up extempore, as it were, by members of the Congress as occasion served; but we have already had to encroach upon their time, as our programme shows, and they seem likely to become "overflow meetings," and to form part of the regular business.

In conclusion, I would ask our colleagues to *trust us.*‡ We are endeavoring, without prejudice or self-seeking, to organize this Congress to the best advantage. Those who remember 1881 will, I am sure, bear witness to full provision being made for medical as well as social profit; and we are working on the same lines now. To secure a large American delegation, we

\* The "Preliminary Announcement" was published in *full* in the March, 1895, HAHNEMANNIAN; this same number contained the editorial comment.

† The subjects mentioned in the "Preliminary Circular" are not suitable for a "centennial" or "international" consideration, they belong properly to an English Congress or an American State Society.

‡ The "Preliminary Circular" is not calculated to instil confidence.

have just—at no little inconvenience to ourselves—postponed the date of meeting to the first week in August, as you have been informed. It will be hard if such articles\* as that which the HAHNEMANNIAN MONTHLY (*et tu, Brute!*) has published should defeat this expectation and impair the success of our gathering.

I am, gentlemen,

Yours very faithfully,

RICHARD HUGHES, M.D.,

*General Secretary,*

BRIGHTON, ENGLAND, March 12, 1896.

### SIMILIA SIMILIBUS CURANTUR.†

To THE EDITORS OF THE HAHNEMANNIAN MONTHLY:

It was with not a little surprise that I saw your editorial in relation to the use of Similia Similibus Curantur and Similia Similibus Curentur. I can only explain its appearance in the April number because of my knowledge of your omnipresence, and almost omniscience, in what concerns the welfare of our school.

If you will allow me, I would like to correct what I consider a most grievous mistake. I refer to your statement concerning the translation of curentur as being "may be."

We cannot deny the fact that considerable time has been spent by the Monument Committee in the discussion of the relative merits of the aphorisms mentioned above. While I am not willing, at the present time, to announce my choice, even though it be clear that Hahnemann himself first used curentur instead of curantur, I do feel that it is only fair to your readers that they should have the same light, to enable them to reach a conclusion, as I myself possess.

I have, on the authority of Dr. A. J. Huntington, Professor of Latin in the Columbian University, as a literal and proper translation of similia similibus curentur, the following:

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\* No article published by the HAHNEMANNIAN could "defeat this expectation" or "impair the success of our gathering," excepting one revealing a poorly conceived and imperfectly planned organization.—EDS.

† In the foot-note of the April editorial on this subject the "e" should read "a."

"*Similia similibus curentur* (the subjunctive for the indicative) ought to mean: *Let like be cured by like.* I cannot imagine any other meaning here which the subjunctive would properly have. Some might suggest a sort of *potential\** sense: *Like may be cured by like—but not fairly, I think.*"

On the authority of the Rev. E. A. Pace, Ph.D., D.D., Dean of the Department of Philosophy of the Catholic University, I have the following:

"*Similia similibus curantur* = (literally) 'Likes are cured by likes;' or (more freely) 'Like cures like.'

"*Similia similibus curentur* = (literally) 'Let likes be cured by likes;' or (more freely) 'Let like cure like.'

This is fortified by Dr. Thomas J. Sheehan and Dr. Charles F. Graham of the same university.

The only condition upon which we can, at the present time, consider such an inscription on the monument is, that through the journals the above translation should be as widespread as the history of the monument.

"*Let likes be cured by likes*" is the highest form of imperative. According to our translation of the Bible, God said, "Let there be light, and there was light."

Yours, respectfully,

J. B. GREGG CUSTIS, M.D.

WASHINGTON, D. C., April 4, 1896.

#### CURANTUR OR CURENTUR.

It will probably be conceded that Hahnemann, who, as is generally admitted, and as his writings—especially the *Fragmēta* and the essay *De Helleborismo*—prove, was a thorough Latin scholar, is the best authority for the correct rendering of his formula. As he always wrote it "*similia similibus curentur*" and, according to his friend Mr. Everist, was annoyed that many of his followers used "*curantur*" in place of "*curentur*,"

\* Suppose we warp the "potential" to the "imperative" and what have we? "Likes may be cured by likes" to "Let likes be cured by likes." In answer to Why? in each case, because, "Likes are cured by likes." The former is two ways of expressing a "rule of art," the latter is the expression of a "law of Nature" underlying the rule.—EDS.

we may say that it would display a lack of *pietas* towards the Founder of Homœopathy were the homœopathic formula on his monument to be rendered in the form which he never used and of which he disapproved. As to the precise meaning of the formula, Hahnemann is again the best authority. In every edition of the *Organon* he has taken care to leave us in no doubt, by giving a free translation or paraphrase of it in almost identical words. The first edition has: "To cure mildly, rapidly and permanently, choose, in every case of disease, a medicine which can itself produce an affection similar (*ὅμοιαν διδοῦσσιν*) to that sought to be cured (*similia similibus carentur*)."<sup>1</sup> The only variation in the other editions is that "certainly" is added after "rapidly." This is plainly a therapeutic rule, a direction for treatment and not the enunciation of a law of cure. It may be epitomized by the words: "treat likes by likes." The verb "curare" is used by Hahnemann in its classical sense, "to treat," and the subjunctive mood is employed in an imperative sense, as in the phrases "fiat voluntas tua," "cedant arma togæ," which one would not translate by "thy will may be done" and "arms may yield to the gown," but imperatively as, "thy will be done," "let arms yield to the gown." In like manner Hahnemann had no idea of saying "modestly," as you suggest, "likes may be cured by likes," but boldly and imperatively: "let likes be treated by likes, and then they will be cured mildly, rapidly, certainly and permanently." Hahnemann had no shrinking modesty about him when it was a question of promulgating his therapeutic doctrine. His formula refers to treatment only, it is a brief summary of the homœopathic method, a guide to practice, "the true, the proper, the best mode of treatment," as he introduces it to us in the *Organon*. The verb "curare" in the sense of "to treat" comes naturally to a German, whose word "cur" signifies "treatment" and the verb "curiren" "to treat." If Hahnemann had wished to formulate the law of nature that underlies his therapeutic rule, he would probably have said, "Similia similibus sanantur." Of course he tells us of this law of nature in many places in his writings, but in his formula he is only concerned with telling us how to treat disease with medicines as he himself explains.

R. E. DUDGEON, M.D.

LONDON, ENGLAND, April 10, 1896.

## EDITORIAL.

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### A LITTLE LEARNING IS A DANGEROUS THING.

THE unfortunate Cassandra, whose prophecies though constantly true were never believed, has always had our unqualified sympathy, a sympathy based on similarity of experience. We too have felt the inward satisfaction of seeing our prevision verified by subsequent events, but have usually endeavored to withhold its expression. Again we take up the rôle of seer, and, at the risk of being regarded as an obstructionist, a conservative, in short, a fossil, wish to point to the danger already imminent, attending the diffusion of medical knowledge through the secular press.

The truth that a knowledge of some facts in anatomy and physiology, if rightly applied, would enable parents to guard their offspring against injurious influences, both pre- and post-natal, and thus gradually to better the general condition of mankind has caused the introduction into our schools, both private and public, of courses of instruction in these branches. Although this leaves the present generation of parents unprovided for, except as they are taught gratuitously and ostentatiously by their children, these latter are liable in their turn to become parents, and the knowledge now acquired may prove of benefit hereafter. We may trust to time to dispel the trifling haziness which the hypercritical might find in such well-authenticated examples of physiological knowledge as the following :

When food is swallowed it passes through the windpipe, and stops at the right side, and some goes to make blood.

The chyle flows up the middle of the backbone, and reaches the heart, where it meets the oxygen and is purified.

The heart manufactures the blood and the liver keeps it going.

Disease is sickness caused by the introduction of some foreign, generally insect substance, as cholera.

Alcoholic beverages greatly obstruct the breaking down of the body.

The exaggerated and in many cases incorrect statements introduced into the text-books as to the effects of alcohol, have no doubt rendered the task of many an attending physician more difficult, while the instances in which their effects have withstood the influences of later years are none too numerous. But let this stand; to such efforts at education we are not opposed, although we do not favor them. They are merely attempts at teaching what is "good for food," a task which according to Genesis, has antiquity at least in its favor. But we must remember that a vegetarian propaganda or an authoritative boom for a universal Salisbury diet has equal rights to be represented, should the advocates of either of these respective methods be in the majority on the school-boards. Further, when the papers teem with instructions as to the First Duty in Emergencies, supplied by philanthropic young physicians, *pro bono publico*, we raise no objections, but begin to scent danger ahead. We grant that good may have been done by these lessons, but generally only where they have been supplemented by further personal instruction, as in the case of the police force.

When the symptoms and course of diseases, not emergency cases, but those whose early recognition is of importance, are spread out in the pages of the "public educator," with a minuteness of detail far beyond the requirements of any community where there are physicians, we raise a warning finger, but when various methods of treatment and their respective merits are given, then we call a halt, a most decided halt. We deny *in toto* the necessity as well as the advisability of imparting such knowledge to the public. The public has no right to expect it and would never have thought of doing so had it not been educated to it by the profession, following, perhaps unwittingly, the lead of quacks and nostrum venders.

These latter first began describing the symptoms of the ailments which they professed to cure, and then, as was to be expected, announced that they alone were in possession of the means of relieving them.

We all know how Koch's discovery was prematurely delivered, and how clamorously his treatment was demanded on all hands. Burgeon's method is still fresh in our nostrils. Its want of the æsthetic element of elegant pharmacy, demanded by an "enlightened public," alone prevented an equally clam-

orous demand for its employment. The antitoxine treatment of diphtheria is the latest case in point, and the dangers alluded to are in a measure already realized. In some communities the remedy is furnished gratuitously, or sold directly to the laity, while in others public opinion demands its use, no matter what the convictions of the attending physician may be, and this, too, while there are still some dissenting voices in the profession as to its general utility. It needs but a little more of such educating of the public to extend the list of obligatory treatments. In this era of legislative over-activity here in America, where the liberty of the individual is being more and more curtailed in matters not political by the temporary and often accidental power of the political majority, under the influence of a few enthusiasts, bigots or cranks, the danger is most imminent. It is none the less imminent because the gradual encroachments have thus far failed to affect our own activities, and yet we, as homœopaths, should have learned by this time that individual freedom in the practice of his profession must be demanded as the inalienable right of every physician. Let it once be denied that every qualified physician has the right to exercise his own individual judgment in the conduct of his profession, "with all due reasonable care, according to his best knowledge," and the way is opened to a worse form of despotism than any against which we have been fighting so long, and in which conflict we have but recently gained our most signal victories. No single man, nor body of men, has a right to prescribe to a legally qualified physician the treatment of his patients; why, then, should we be willing to grant to the irresponsible voice of superficial, ignorant or half-educated public opinion what we deny to our equals in our own profession? What means all this talk about protecting the public against incompetent physicians, when we ourselves are raising up hosts of far more dangerous enemies to the public weal in the persons of newspaper-educated doctors?

In our earnest desire unselfishly to further the cause of prevention, as preferable to cure of disease, we have seemed to forget that the former has only to do with the laws of health and with right living, and is a proper subject of instruction to the public, while disease, no matter in what form, trifling or

serious, is a specialty, and should be treated alone by the specialist "made and provided therefor," the physician.

Let the shoemaker stick to his last.

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#### A SUGGESTION.

We are pleased to learn from the published accounts of the recent meeting of the State Board of Homœopathic Medical Examiners that it has again placed homœopathy on record as being in favor of any advance in the standard of medical education required of prospective practitioners. "It unanimously decided that the Board is now ready to raise the standard to 75 per cent. in each branch or equal that established by the New York Regents. The Board also desires to have the preliminary examination equal that demanded by the New York Regents."

We are in full accord with the desire to prove that homœopaths as a school have nothing to fear from any such advance, and are ready not only to follow but to lead in the crusade against ignorance and incompetence. We are sorry, however, that the circumstances of the times have not seemed favorable to more independent action.

The establishment of a 75 per cent. in every branch, we think, would be a mistake. It disregards entirely the relative importance of the several branches in which examinations are conducted. It places subordinate subjects, a general acquaintance with which is all that need be expected of the ordinary physician, on the same footing with those main ones, a thorough knowledge of which should be required of every physician. Surely a moment's thought will show the undesirability of this. The students will pay undue attention to these subordinate studies to the detriment of thoroughness in the more important ones—"ars longa, vita brevis est"—even with a four years' course. If 75 per cent. is required in chemistry, for example, surely we can hardly consider the same as indicative of proficiency in obstetrics, or practice, or *materia medica*. Or if 75 per cent. is as much as we think necessary in these latter subjects, we are hardly warranted in requiring the same in the others. The ideal would be of course to demand and to get 100 per cent. in each branch.

Figures lie, and there is nothing so absolutely misleading as averages or percentages when applied to small numbers. It seems hardly possible, however, to do away with their use under the present crude system. Our ideal would be the appointment of examiners with some reference to each one's individual fitness to judge of the capability of the candidates in some particular subject, and then let them be given the power to vote, "pass" or "reject," without regard to percentage. Then by making it obligatory to pass in certain main branches and in a proportion of the remainder, the certificate of the Board would come to be regarded as honorable as a testimonial as the diploma of a college. The semi-publicity at present existing in the matter of questions and answers, together with the right of appeal to the whole Board by rejected candidates, would prevent all abuses. Then not sections of the State of Pennsylvania would be represented in the Board, but special fields in the Domain of Medicine.

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#### THE INTERNATIONAL CONGRESS OF 1896.

It is to be regretted that those responsible for the sixth quinquennial meeting of the International Congress of Homœopathic Physicians have apparently not recognized the importance of the occasion. This being the first and only opportunity in the history of homœopathy for celebrating the centennial anniversary of the great medical reformation promulgated and inaugurated by Samuel Hahnemann, the American profession naturally anticipated a programme of far different character from one found suitable for a meeting of a British medical congress or an American State society. The preliminary circular of the permanent secretary was received in February, and nothing has since been forthcoming. On reading this announcement it is painfully astonishing to find nothing indicative, in the slightest degree, that the year A.D. 1896 marks the close of the first century of homœopathy—in fact, it contains nothing of sufficient importance in either scope or character to attract international attention. What it does offer is good; it is excellent as far as it goes; but its limit is certainly that of a State society meeting, and it is not worthy

the amplitude of opportunity offered by the present great and rare occasion. The profession is facing the close of one hundred years since Hahnemann published his "Essay on a New Principle for Ascertaining the Curative Power of Drugs" and announced the first principles of the science of homœopathy, and this, above all other times, is a fitting season for the profession of the world to face about and review the history of the century and draw the lesson of guidance for the future.

The American Institute of Homœopathy has decided to critically examine the status of the law of the similars, considering, first, its logical basis; secondly, its experimental demonstration; and thirdly, its clinical efficacy and superiority. And perhaps it is well that the International Congress did not arrange to do the same. There are other questions, however, affecting the general welfare of the homœopathic profession as fundamentally important which ought to claim and occupy a large part of the time at the disposal of the Congress—e.g., there should be provided a critical analytical review of what homœopathy has accomplished during the past one hundred years, not a mere statistical enumeration, but a philosophical reduction of what has been the influence of homœopathy on the medical world in this century now closing. Then should follow a report of a searching inquiry of why more has not been accomplished in this vast period of time, candidly reviewing the causes and influences operating against a more general acceptance of the truth of homœopathy by our opponents, estimating honestly and pointing out clearly the faults that are at our own door, and giving the measures necessary of adoption to place the law of similars on a surer foundation and facilitate its demonstration to the general medical mind, thus paving the way for the universal recognition and adoption of the law, and rule of practice, for which we stand. To do less is unworthy of the Centennial of Homœopathy and the International Congress.

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TREATMENT OF SOFT CHANCRE.—Neisser (Brealau) recommends cauterizing the ulcer with pure carbolic acid which he has used for many years in his clinic. It causes neither pain nor consequent induration. As a subsequent dressing he employs iodoform and a salve containing 2 per cent. of argentic nitrate and 20 per cent. of balsam of Peru, to disguise the odor.—*Hospitals Tidende*.

## GLEANINGS.

### GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D., AND FRANK H. PRITCHARD, M.D.

**TREATMENT OF POISONING CASES.**—Dr. Lewin, of Berlin, sets forth the three following indications in a case of poisoning : To eliminate the poison from the organism as rapidly and as completely as possible ; to modify it chemically as much as possible, that its toxic properties be neutralized ; and to combat as far as possible the resultant disturbances in the various organs.

In the majority of cases the poison has been taken into the stomach. Hence, an emetic or washing out the stomach is indicated. An emetic is much inferior to irrigation, as it cannot remove those portions of the poison which adhere to the gastric wall. If a stomach-tube be not handy, any flexible soft rubber tube of eight to ten millimeters in diameter, and two and a half metres in length, will suffice. To this a funnel is attached ; then the tube is introduced. Even in case of syncope one should not hesitate to employ the stomach-tube, for in grave cases of poisoning one may hope to remove a portion of the poison. Also in poisoning following hypodermic injections, or those made into the pleura or the cavities of cysta, one should not refrain from washing out the stomach, for certain poisons are excreted by the gastric mucous membrane, as morphine and iodine. In certain cases one need not limit one's self to plain water, but if the poison be recognized the specific antidote may be introduced, in solution, through the tube ; for example, a solution of the sulphate of copper in phosphorus poisoning [or of permanganate of potash, which is a more certain chemical antidote of this poison, as well as of opium and its alkaloids—Eds.] ; or of sulphate of soda in cases of poisoning by carbolic acid [dilute vinegar is also recommended—Eds.] ; lime-water in that of oxalic acid and its salts ; a solution of sulphate of zinc in that of acetate of lead.

In incessant vomiting a solution of the muriate of cocaine, 0.10 to the litre, may be introduced through the tube ; a mild solution of the perchloride of iron will control gastric hemorrhages after poisoning.

If washing out the stomach cannot be done then emetics must be given. Here he advises only three measures : drinking a glass of cool water containing eight to ten grammes (3ij-ijs) of good mustard flour ; or one gramme (grs. xv.) of sulphate of copper, or a hypodermic injection of two egms. (gr.  $\frac{1}{2}$ ) of apomorphine. Neither oily nor fatty fluids nor tepid nor hot water are to be used to produce vomiting, as they will dissolve certain poisons. Another indication is to eliminate that portion of the drug that has reached the intestine by purgatives and clysters. Here the sulphate of soda or magnesia and Seignette salts are best given. If the poison has penetrated into the blood but little is to be expected from antidotes except where a direct physiological antagonism is known as with morphine and atropine and atropine and pilocarpine. Instead of employing a long series of antidotes the physician rather should direct his efforts to eliminate the drug from the body as rapidly as possible. Heart depression is to be met with stimulants preferably administered by the rectum as the peripheral circulation may be sluggish or arrested. Aqua ammonia, thirty drops to two cups of water, or brandy, a teaspoonful to a cup of water with addition of a little gum arabic, camphorated oil (10 per cent.), mixed with any oil or a strong infusion of coffee. Hypodermically, the best stimulant is tincture of musk—three to four grammes. Impending paralysis of the respiratory centre require cold affusions to the back of the neck and artificial respiration. He warns against allowing inhalations of ammonia to be given as it only inhibits the already weakened nerve centres [and is quite prone to give rise to a severe subsequent conjunctivitis or even opacity of the cornea.—Eds.].

In tetaniform convulsions, inhalations of ether or a clyster of an infusion of valerian root. A rectal injection of three grammes of paraaldehyde in the yolk of an egg is also useful as a sedative. Chloral is contraindicated as it is too depressing to the heart. In grave and profound alteration of the blood (as with the chlorate of potash or hydroxylamin or possibly in carbonic acid gas poisoning) an abundant bleeding may be done and then followed by intravenous infusion of double the quantity of the physiological salt solution.—*Il Progresso Medico*, Nos. 9 and 10, 1891.

**STOMATITIS ACCOMPANYING THE ERUPTION OF MEASLES.**—Prof. Comby calls attention to the buccal eruptive symptoms of the measles. If one examines with care the mouths of children with measles one will notice a general swelling, yet which is moderate, of the gums, cheeks, tongue, palate, etc., while the whole mucous membrane is turgescent, a violet-colored redness of all these parts with or without increased salivation, and an exudate, a deposit which is pultaceous, opaline, whitish, creamy, covering partially and inequally the gums, lips, cheeks, floor of the mouth, etc. This same deposit sometimes forms festoons around the teeth. It may be removed with the finger without causing the subjacent mucous membrane to bleed. It may precede the eruption which it always accompanies and with it it disappears. It causes the patient neither pain, distress nor reaction; it is latent and insidious, and, though without gravity, it is both an indication of the active participation of the mucous membrane in the eruption and of the need of buccal cleanliness to prevent complications. It may in children with faulty or slow dentition give rise to actual stomatitis.—*La France Médicale*, No. 4x, 1895. [Prof. Nil Filatoff, *Diagnostik und Semiotik der Kinderkrankheiten*, Stuttgart, 1892, p. 420, calls attention to the diagnostic importance of the changes of the mucous membrane of the soft palate where, from 24 to 48 hours before the eruption on the face, a spotted erythema appears, and it is so typical that a diagnosis of measles may be made in the prodromal stage. It is, therefore, called the prodromal exanthem. It may also be noticed on other portions of the buccal mucous membrane, especially on the inner surface of the lips and cheeks as well as on the eyelids.—Eds.]

**Poisoning by Atropine.**—Prof. C. Binz reports the case of a patient of fifty years with an eye affection where, instead of pilocarpine, an injection of atropine (8 mgms.) was made. A short time after the patient was found in bed supported by assistants and nurses. Her face was distorted, red and expressed a death-like anxiety; her eyes were glittering, and with one hand upon her heart she was gasping for breath with rapid respirations; her pupils were dilated to the utmost, which led to a suspected mistake in the drug. This was confirmed by the bottle on the table at the bedside. An immediate injection of morphine (.2 egms.) gave a decided improvement in five minutes, so that she was able to lie down and the sense of suffocation had disappeared. Her pulse, which was before not to be counted, sank to 100; her respiration to 21 in the minute and the almost hydrophobic dryness of her mouth and throat decreased so that she was able to expectorate. Improvement continued to complete recovery. He relates a second case where ten times the maximal dose of atropine was given by mistake instead of morphine. A condition of excitement resembling a maniacal attack almost instantaneously followed, which was relieved by morphine. A third interesting experiment was where a physician by mistake injected 4 mgms. of atropine in an attack of renal colic. Immediately perceiving his mistake he injected 3 egms. of morphine, telling the patient that he had injected too little in the first hypodermic dose. The patient only complained of a dryness of the throat later; otherwise no other symptoms were noticed. He is a warm advocate of the striking therapeutic antagonism of these two drugs.—*Berliner Klinische Wochenschrift*, No. 46, 1895. [Prof. Kobert, *Fortschritte der Medicin*, 1891], is almost decidedly convinced of the mutual antagonism of these alkaloids. He mentions a case where in a case of morphine poisoning twenty-four times the maximal dose of atropine was given with a successful outcome.—Eds.]

**DISEASES OF PRINTERS.**—Dr. C. Heimann, of Berlin, from examination of the statistics of the Berlin printers with regard to mortality and morbidity, finds that pulmonary tuberculosis in nearly one-half is the cause of death, thus making it one of the most unhealthy of occupations. Rheumatism is extremely frequently observed, possibly covering as a mistaken diagnosis, lead poisoning. This latter

affection is by no means as frequently observed among printers as is generally assumed. A chronic condition of neurasthenia which is seemingly dependent upon lead poisoning is often met with, yet a differentiation between chronic alcoholism and lead poisoning is occasionally difficult. Eye diseases and decrease of visual power are right frequently observed. Varicose veins and their resultant ulcers, a consequence of standing for hours, also form a large percentage of the cases. Since the hand-press has been displaced by that driven by steam, the frequency of hernia has been noticed to diminish. The predominance of consumption in the morbidity lists is ascribed to the inhalation of irritating lead dust, the long-continued and exhausting work, as well as the overheated condition of the printing rooms. In general, printers are well paid and robust persons. A chronic condition of catarrh being produced the bacilli which are expectorated about by infected subjects easily find a favorable soil. The chief points of entrance of the metal in lead poisoning are the lungs and the digestive tract. The unhealthy state of this occupation may easily be diminished by adopting proper hygienic regulations.—*Deutsche Medicinische Wochenschrift*, No. 39, 1895.

**POLIOENCEPHALOMYELITIS.**—Dr. S. Kalischer has recently observed a case of that curious affection, Erb's disease, or polioencephalomyelitis. The patient, a draughtsman by occupation, and fifty years of age, was attacked by the gripe in December, 1893, and in four weeks he was able to resume his business. In April, 1894, while at drawing he was suddenly seized with diplopia and ptosis of the upper right eyelid; the eye muscles were a little later affected, and finally, those of mastication were also involved. His lower jaw fell involuntarily; he could no longer whistle, smoke, etc.; a short time after the muscles of the back of the neck were involved so that his head fell forward. Finally, disturbance of swallowing also appeared, and he came near suffocating. These various symptoms ameliorated at the beginning of 1895, and after feeling fairly well for four months, they reappeared last May, and still persist. Recently his limbs have lost in strength; he cannot raise them, and they rapidly become tired. His trunk muscles are but little affected, yet they seem to tire more rapidly than normal. No disturbance of sensation.

Up to the present, but five cases of this disease are known. Its prognosis is variable; sometimes the disease may last for several years, and recovery follows, while again the patient may die suddenly from paralysis of the muscles of deglutition or respiration. It is very probably of toxic origin, for it is noticed to follow infectious diseases as typhoid fever, diphtheria, the gripe, etc. Several months may intervene between the infection and the appearance of bulbar symptoms. It cannot be confounded with progressive bulbar paralysis, for the reaction of degeneration is absent, as well as the fibrillary twitching and the muscular atrophy. In bulbar paralysis the atrophy of the muscles precedes the paralysis; this atrophy is never seen in polioencephalomyelitis.—*La Semaine Médicale*, No. 49, 1895.

**Poisoning by Carbolic Acid.**—Dr. W. Sekowski, of Warsaw, Poland, in an anæmic woman suffering from a chronic leucorrhœa following an abortion, irrigated the vagina with a 3 per cent. solution of carbolic acid and curretted the uterus; the next day an injection of a 2 per cent. solution. The day afterwards an assistant injected one of the same strength. In twenty minutes the woman became unconscious, with trismus, clonic convulsions of the extremities, weakening of the heart's action and numerous rales in her lungs. The writer succeeded in emptying the vagina of 100 gms. of retained carbolic solution, and with the aid of applications of active restorative measures succeeded in seven hours in causing the symptoms to disappear. He excluded absorption by the uterus or penetration through the tubes, and is certain that absorption took place through the vaginal mucous membrane in an anæmic subject who was peculiarly susceptible to the drug. The convulsions were pronounced symptoms of poisoning.—*Przeglad Chirurgiczny*, tom. ii., zeszyt iv., 1895. [Prof. Kober, *Lehrbuch der Intoxikationen*, Stuttgart, 1893, p. 224, amongst other series of phenomena following ingestion of carbolic acid, calls attention to the liability of sudden collapse after irrigation of the thorax, abdomen or uterus with solutions of the disinfectant. If the subject does not immediately succumb the collapse may be relieved and be followed by delirium, states of excitement which alternate with confusion of mind, vertigo, exhaustion, roaring in the ears, contraction of the pupil and profuse sweating. The temperature may vacillate irregularly. Haemoglobinuria has been observed.

The drug is excreted by the kidneys. On addition of a solution of the chloride of barium no precipitate of the sulphate of barium is formed as all the sulphates of the organism go to neutralize the poison in the body.—Eds.]

**PSEUDO-MENINGITIS FROM CREOSOTE.**—Dr. Fassans reports the case of a student of pharmacy of twenty-six years who, in the second stage of pulmonary tuberculosis, was treated by hypodermic injections of creosoted oil 1:15 in progressively increasing doses of 10, 20, 30, 40, and finally up to 140 gts. In three weeks, December 6th, the urine was noticed to be dark and the dose was decreased to 60.0. On the 9th, he was found extended on his bed delirious or alternating with a half-comatose state. He could give no information with regard to his case; but a bottle of the oil and a hypodermic syringe were found near him. The pupils were dilated; the temperature 38° C.; pulse regular, 100; general hyperesthesia was well marked. He had vomited, and he apparently had headache. A diagnosis of tubercular meningitis was made. In three days the symptoms had improved and he became partially conscious; he passed considerable dark-colored urine resembling that due to poisoning by carbolic acid. In two days he was able to leave the hospital. Though on first examination the symptoms resembled a tubercular meningitis, yet many characteristic signs were absent, as the fever, irregularity of the pulse and respiration, convulsions, paralysis and stiffness of the neck. The error was favored by the appearance of signs of cerebral irritation in a subject who was known to be tuberculous. A number of similar cases have been observed.—*La France Médicale*, No. 4, 1896.

**DIAGNOSIS OF MENINGISM.**—Dr. L. Gailliard recently observed a typical example of hysterical meningism in a young infirmiere who for several days had suffered from terrific headache and violent epigastric pain with incessant vomiting, constipation, hyperesthesia, meningitic stiffness of the neck, yet fever was absent. A complete recovery followed.

In a second case, a young man of 26 years, who was not hysterical, the pseudo-meningitic state followed a violent emotion. Being employed in a large store in Paris, he was unjustly accused of having stolen a package which was misplaced. Thence followed an attack of stupor and prostration. He sat doubled over like the trigger of a gun, en chien de fusil. There was a characteristic meningitic stiffness of his neck, violent epigastric pain, fetid breath, loss of appetite, hyperesthesia, retention of urine and constipation; no fever. He had nightly delirium, was very weak and extremely emaciated, an actual marasmus. These symptoms developed twelve days after the accusation. Fortunately, after being for three weeks under treatment, he awakened as from a fever, suddenly spoke, ate food, etc. Fifteen days later he was convalescent and left the hospital.—*La France Médicale*, No. 1, 1896.

[Dr. Seglas, *La Semaine Médicale*, No. 5, 1896, also calls attention to this term, which he claims is a cloak to cover a number of conditions. Alienists recognize one condition which goes under the name acute stupor or acute delirium, two different states which are classed under this head; these are acute stupor and acute delirium. Between these two extremes there are recognized various transition states which he calls pseudo-meningitic varieties of acute stupor. They may be independent or be due to primary physical or moral shock. In cases of toxic or infectious origin the diagnosis may be very difficult on account of the fever and its characteristics, the state of the pulse, etc. These patients do not present the characteristic stigmata of hysteria, and, indeed, their very presence is not sufficient to attribute the symptoms to hysteria. Such patients may die, and the necropsy is negative—(venous stasis, edema). Sometimes the patient recovers and later dies of meningism or true meningitis. The diagnosis should be unfavorable, especially if the disease be of toxic or infectious origin.—Eds.]

**DIAGNOSIS OF MALIGNANT TUMORS OF THE LUNGS FROM THE SPUTA.**—Dr. Betschart records a case of primary carcinoma of the lungs where examination of the sputum enabled a diagnosis to be made during the life of the subject. Under the microscope large roundish or roundish-cornered cells were detected either alone or chiefly aggregated together in masses. By comparison the sputa of pulmonary carcinomata and sarcomata is, even to the unaided eye, different. In the former the fragments of tissue are more prone to be small and very small size, while the more coherent sarcoma is expectorated in larger pieces, which are easily noticeable and several centimeters in length.—*Muenchener Medicinische Wochenschrift*, No. 51, 1895. [Da Costa, *Medical Diagnosis*, Philadelphia, 1884, p. 307,

calls attention to the similarity clinically with tubercle of the lungs. Cough, night sweats, haemorrhage, gradual wasting belong to both diseases, as do the signs of pulmonary consolidation. But cancerous formations are usually limited to one lung. There are no râles, but signs of greater consolidation than in tubercle. The sputa are either purulent or like currant jelly. Further, a cancerous tint of the skin may be present. In tubercle the pain is shifting and transitory; in cancer it is much more constant and much more severe.—*Eds.*]

**A CASE OF CHRONIC DIPHTHERIA.**—Drs. Legendre and C. Pochon, of Paris, treated a child who, in less than three years, had diphtheria three times, once tonsillitis, once stomatitis with pseudo-membranous rhinitis, and a third time tonsillitis with rhinitis. In September, 1894, diphtheritic bacilli were detected. During the following fifteen months a bacteriological examination was made thirteen times, and the characteristic bacilli were found each time, either virulent or non-virulent, under all their various forms and at times alone, while at others they were associated with staphylococci. Frequent irrigation of the nose with a 5 per cent. solution of permanganate of potash solution would cause the bacilli to disappear or to be reduced in number greatly. If these were discontinued they would increase again in number. The child while under treatment was comparatively well. When treatment was stopped would become pale and weak and lost its appetite. The writers assume that the bacilli had a "nest" in one or another gland.—*Hôpital Tidende*, No. 3, 1896.

**SUDDEN DEATH FROM RUPTURE OF A CARDIAC BLOODVESSEL.**—Dr. Schwalbe, of Berlin, reports the curious case of a merchant, a wine agent, of 56 years, who fell sick in March, 1895, with dyspnoea and palpitation. An examination revealed emphysematous dilatation of the lungs; moderate dilatation of the heart, especially out over the mammary line one and a half fingers' breadth; and a systolic murmur over the aorta, while the pulse was apparently normal. Over the right pulmonary apex, as well as the supra and infra-clavicular regions, there was an area of slight dulness. He had a doubtful chance thirty years before; was a moderate drinker. About a month before his illness he had an attack of haemoptysis, so that in the course of about two days he had expectorated about a tumblerful of pure blood. A diagnosis of stenosis of the aortic aperture, due to general arterio-sclerosis, was made. Symptoms of cardiac asthma, with angina pectoris, later developed. December 6th he had a severe attack of eight hours' duration, when his condition was desperate. An aortic aneurism was suspected on account of the so-called "premonitory symptoms" (Hampelm) of aortic aneurism being present; slight dulness over the manubrium sterni, with the area in the supra- and infra-clavicular regions; occasional difference in the pulse of the two sides and the repeated slight haemoptysis. In the first weeks of December, after a day of fair health, he suddenly fell over dead. At the necropsy, the corpse was decidedly anaemic, the heart was two and a half times as large as his fist and double the normal weight, and one of the large vessels of the heart itself presented an opening half as large as a bean. No aneurism. The aortic valves were greatly altered, two being grown together, so only two were visible. The descending portion of the aorta was markedly sclerotic.—*Berliner Klinische Wochenschrift*, No. 51, 1895.

**SOMNOLENCE STATES OF HEPATIC ORIGIN.**—Dr. L. Levi directs our attention to a class of nervous states consecutive to liver diseases, which present a tendency to somnolence, and which may even become an actual coma. Murchison has described this as to be observed in advanced states of cirrhosis of the liver. The writer has recently seen two such cases where this hepatic somnolence was particularly striking.

In the first case it was an alcoholic and gouty subject who, after an attack of sore throat of moderate severity, commenced to grow weak, to emaciate and suffered from frequent attacks of nose-bleed; then his lower extremities became oedematous. From this moment the patient commenced to suffer from irresistible somnolence, though at night he slept well. For example, being at the hospital he would fall asleep when his wife visited him, or while his finger was being punctured for a drop of blood. During half an hour he would fall asleep and awaken several times, his sleep being light and interrupted. He finally succumbed, greatly emaciated from marasmus. At the necropsy, a cirrhosis of the liver was discovered of periportal origin, and probably dependent on an infection from the tonsillitis.

The second case was a woman without any nervous hereditary or personal taint antecedents, and who six years before had suffered from an attack of gall-stone colic. Since then she had felt slight pain in the region of the liver, lasting from a few hours to several days, and unaccompanied by icterus. These disappeared to reappear after two years. This time they were associated with an invincible somnolence ; she would fall asleep at any moment, even while in society, though at night she rested well. Soon after she was seized with a typical attack of gall-stone colic, the pains ceased and the sleepiness vanished. Later, she experienced pains in the right hypochondrium, and the somnolence reappeared. This case is singularly conclusive, for the simultaneous appearance of the colicky attacks and the somnolence point to an actual cause and effect.—*La Semaine Médicale*, No. 4, 1896. Dr. Joffroy has recently called attention to the relation of visceral affections to mental diseases, and cites in support of this the case of an alcoholic male subject who, at the age of fifty years, was affected with atrophy of the liver, to which he succumbed, and who presented, during the course of his disease, symptoms of (pseudo-) general paralysis. The nervous disturbances of hepatic origin are only just beginning to be understood. Klippel, for example, has described a form of insanity of hepatic origin ; Mya, a hepatic eclampsia in children, which is fatal ; Charrin, a preliminary hepatic delirium ; Roger, a hepatic coma. Joffroy, in his case, noticed a parallelism between the nervous symptoms which resembled general paralysis and the liver symptoms. The former would improve as soon as the latter ameliorated.—*La France Médicale*, No. 3, 1896. [Dr. Charrin records another case of "folie hépatique." A man of 52 years, without hereditary antecedents, but a drinker, had been unable to drink a drop of liquor for a year. He has an enlarged liver, and, with an aggravation of his liver disease, he presents a delirium resembling that due to alcohol.—*La France Médicale*, No. 4, 1896.—Eds.]

**VOMITING IN THE DIAGNOSIS OF SCARLATINA.**—Dr. Valli Attilio thinks that in the vomiting of scarlatina we have a means of diagnosing the disease before the appearance of the exanthem as well as in the anomalous form. It is, as a rule, sudden. The child has been perfectly well ; has complained of nothing nor has eaten anything improper, but all of a sudden it commences to vomit. Its strength will be found depressed, its general condition below normal, and the pulse will be increased. The tonsillitis also frequently precedes. In anomalous, benign forms there may be only vomiting and sore throat. The writer has often, in scarlet fever epidemics, been called to treat children with nephritis who had a history of having vomited several days before and had a sore throat. Thus, in these anomalous cases, one may prevent the spread of the disease to others, and be on one's guard for renal complications.—*Rivista Clinica E Terapeutica*, No. 12, 1891. [Prof. N. Filatoff (*Diagnostik und Semiotik der Kinde Krankheiten* Stuttgart, 1892), to the three cardinal diagnostic signs, exanthem, tonsillitis and fever, adds the vomiting. He regards it also of diagnostic importance. It either appears but once or is very obstinate at the very beginning. In severe cases the vomiting may be repeated, in the first twenty-four hours, ten, twenty or even thirty times. Its intensity, in a measure, depends upon the gravity of the disease, and a very frequently repeated vomiting must be regarded as an unfavorable sign. It rarely extends beyond twenty-four hours in the most obstinate cases. It is very frequent in this disease compared with other infectious diseases. It is a differential symptom from measles.—Eds.]

**DO MEASLES RELAPSE ?**—Drs. Chauffard and Lemoine again bring forth the question whether measles may relapse or not and whether the subsequent eruption is not a simple recession or possibly a roseola or a rubella, or even an accidental or remedial eruption followed by true measles. Indeed, all these states may simulate a relapse. They record eleven cases of true relapse, observed during three months of an epidemic of 1895. The intervals have been quite variable : 27 days, 20 days, 12 days, 21 days, 12 days, 1 month, 14 days, 40 days, 20 days, 1 month and 21 days respectively. No definite period can be fixed for the prodromal stage ; if the first attack be known the succeeding interval can not be redetermined thereby.

As to the relative gravity of the two eruptions, all sorts of combinations were noticed, but none, of either the primary or second attacks were grave and no malignant, complicated or anomalous.—*La France Médicale*, No. 1, 1896. Dr. Buequoy regards such cases as merely two stages of the same case ; the virulence of the exanthem not being exhausted by the first outbreak.—*Ibidem*. [Dr. Sevestre, *Ibidem*, No. 3, 1896, has observed two very striking examples.—Eds.]

## GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D. AND H. L. NORTHROP, M.D.

**ATROPHY OF THE TESTES AND PROSTATE AFTER SECTION OF THE VAS.**—Isnyrdi relates the case of an old man, st. 72, whose vas he had divided six weeks before for enlarged prostate. For the last year the man had suffered from the advanced symptoms of enlarged prostate, which had been rebellious to all forms of treatment. The prostate was much enlarged, and the patient had to put himself in odd positions before he could micturate.

Twelve days after the operation the symptoms began to diminish, and disappeared within a month. He can now hold his water for seven hours during the night, and pass it voluntarily and without pain. The urine, which was before purulent and blood-stained, is now clear and normal. There is induration over the incision, extending down to the epididymis, the testicles are diminished in size and the prostate is impalpable.—*Reforma Medical*.

**KEROSENE IN SURGERY.**—Schirman recommends kerosene in cases of ulcers, especially atonic and indolent ulcers. He smears them with commercial kerosene, either pure or diluted (from 33 to 50 per cent.) with alcohol, with a small camel's-hair brush or with a piece of gauze soaked in the solution.

The advantages of the use of kerosene for such cases he summarizes as follows: It produces healing in a comparatively brief space of time; it is economical and easily obtained; the ulcers have never been complicated with any erysipelatous process; it does not produce constitutional poisoning through the wound by absorption as other antiseptics sometimes do; it has not the intolerable smell of others now in use; and the formation of a cicatrix on the ulcers is hastened. Kerosene, having a local irritating action on the wound, undoubtedly possesses also disinfecting properties. This is of great value, for actual facts show that persons residing in the kerosene oil districts are protected against ailments of an epidemic character, such as cholera, etc.—*New York Medical Journal*.

**GRAFTS OF DRY SKIN IN SKIN GRAFTING.**—Lusk (Warsaw) in a case of extensive burns tried taking a piece of dry skin coming from a burn of the second degree in order to make a skin graft upon an extensive burned area. It was carefully cleansed and moistened and a piece two and a half cms. square was cut into twelve strips and laid upon the wound. The result was excellent for they formed little islets of epidermis which, extending, finally covered the whole wound. This method is easy of application for the epidermis may be obtained by means of a blister.—*La Semaine Médicale*.

**THYROIDIN IN HYPERTROPHIC CICATRICES.**—White, in a patient who, after receiving an incised wound from a fragment of mirror glass, which left a disfiguring and hypertrophied cicatrix of the face which would not be influenced by any manner of treatment, finally administered tablets of thyroid extract (0.3), two to four a day. All local treatment was discontinued, excepting application of collodion. Under the influence of this drug, which produced, among other symptoms, tachycardia and fever, the cicatrical tissue diminished gradually, so that in eight weeks it was on a level with the surrounding skin. Though this was a simple hypertrophic scar, he would advise its trial in true keloid.—*Weiner Medizinische Presse*.

**PLASTER-OF-PARIS BANDAGE—TO REMOVE EASILY.**—In *La Semaine Médicale*, Gigli recommends a plan to facilitate the disagreeable task of removing plaster-of-Paris bandage, which is worth considering. After applying the usual layer of cotton around the limb, a layer of parchment paper, previously moistened and wrung out, is wrapped above this, and then a large-sized cord, well rubbed with vaseline, is placed upon this in the direction that one wishes to saw open the apparatus. Over this the plaster bandage is laid on. When, in the course of time, the dressing is to be removed, the cord, whose ends have been tied together, is loosened and one end tied to a thin steel wire which has been nicked at close and regular intervals, and the wire drawn through. Each end of this wire is attached to a handle, and with a backward and forward motion the plaster is at once sawed through, after which the dressing may be immediately laid off.

**TREATMENT OF COLD ABSCESES BY INJECTION OF CAMPHORATED NAPHTHOL.**—Bonet, at the hospital for tuberculous subjects at Berck-sur Mer, France, has treated fifty-one cases of tuberculous coxitis and forty-nine cases of Pott's disease by injections of camphorated naphthol. Of the fifty-one cases of coxitis, forty-four were healed without formation of a fistula; four with a temporary fistula; in two, resection of the hip had to be done; one left the hospital with a persistent fistula. Some cases were induced to heal in one to two months by one to three injections; others required a longer treatment and several injections. The abscesses associated with old hip-joint disease heal much more rapidly than recent cases. In the forty-nine cases of Pott's disease forty-four were healed without accompanying fistula in fifteen days to one year. The injections are not painful and no reaction follows. Experiments on animals have demonstrated that camphorated naphthol has an exclusively antitubercular action which explains the poor results obtained with it in open tuberculous abscesses where a mixed infection has already occurred.—*Thèse de Paris*, 1895.

**TREATMENT OF SOFT CHANCRÉS WITH FORMALIN.**—Frank recommends formalin in the treatment of soft chancrēs. Though the local application is slightly painful it destroys the specific virulence of the ulcer in an astonishingly short time. Already in twelve hours the surface of the ulcer is dry, and in not very deep ulcers a single energetic application upon a tuft of cotton rolled around the end of a match will suffice. If the ulcer be deep, then it is advisable to repeat the application in two days. After cauterization the chancrē is covered with a piece of gauze. In about six days the cauterized layer will be cast off, exposing a nearly smooth surface, which will heal in one or two days without any induration. In several cases it was observed that the resultant moist and glistening surface showed no tendency to heal. In all these cases induration and enlargement of the glands followed, an expression of syphilitic infection. This characteristic might be used as a differential diagnostic measure.—*Berliner Klinische Wochenschrift*.

**MASSAGE IN FRACTURES OF THE UPPER PORTION OF THE HUMERUS.**—Lucas.—Championnière, who for many years has advocated treatment by massage of fractures of the forearm and leg, now speaks warmly of this method in fractures of the humerus near the shoulder-joint. In tearing loose of the tuberosities or fracture of the anatomical neck, which are not accompanied by decided displacement, massage may be begun at once. At first the manipulations should be made gently, and here, above all things, it is to be sought to attain as high a degree of function as possible. As soon as one can passive motion should be attempted. Circumduction is the most important movement. The arm should, therefore, be lifted as high as possible under the circumstances and treatment be directed not only towards rendering the joint movable but also to prevent the worst complication, paresis or paralysis of the deltoid. No extreme motions are called for. To attain this result no splints are necessary; in two to three days a bandage is no longer needed. The support of the patient's clothes is quite sufficient, and at the same time it does not prevent the slight movements, which are a certain guarantee against atrophy of the shoulder muscles. In severe fractures the fragments are replaced under an anesthetic and the first massage is immediately done. As a support a pad is placed in the axilla and a circular bandage applied. Consolidation sets in astonishingly quick, and one need have no fear of overriding or displacement of the fragments if care is used in making the passive movements. Four to five days are enough to insure a certain degree of solidity when massage may be done daily. The bandage may be worn for ten to twelve days, after which a simple sling will suffice in order to give the shoulder and hand a certain amount of mobility. To prevent dislocation during massage the left hand is slipped into the axilla back of the seat of fracture and with the right the manipulations are made. The method is the same in all varieties of fracture, either stroking with the palmar surfaces of the fingers or with both thumbs. An assistant is necessary occasionally to immobilize the arm. His results have been entirely satisfactory. The pain soon disappears, and even in old persons he attains good function. He regards these fractures as innocent lesions; even in severe cases he obtains complete union and good functional results.—*Norsk Magazin for Lægevidenskaben*.

**LACERATION OF THE AXILLARY ARTERY IN REDUCTION OF AN OLD DISLOCATION OF THE SHOULDER JOINT.**—Makara (Buda-Pest) records the case of a laborer

of forty-two years where a reduction of a luxation of the shoulder-joint of forty-five days' duration was attempted under an anaesthetic. At the first traction and rotation the head of the humerus moved from its former place; but an attempt to force it into the cavity of the joint not only failed but a tumor appeared under the pectoral muscles, and the radial pulse was found to have disappeared from the corresponding side. Though the subclavian artery was ligated a few hours later, it was impossible to prevent gangrene of the arm. The patient died on the seventh day after the operation, of sepsis. The necropsy revealed a right-sided subcoracoid luxation of the humerus complicated with a fracture of the acromion, a laceration of the axillary artery, non-gangrenous thrombosis of the axillary artery, gangrene of arm and putrid infection. In a number of cases found in the literature, where they do not appear to be so rare, death took place from sepsis due to gangrene of the arm or from violent haemorrhage. The seeming causes of the recorded cases were: 1. Violent reduction. 2. Great age, with atherosomatous bloodvessels. 3. Adhesions between the bone and artery. 4. Simultaneous fracture. — *Pester Medicinisch-Chirurgische Presse.*

**TREATMENT OF SUPPURATION.**—Reichel (Wuerzburg), from a long series of animal experiments and observations on man finds that even very extensive phlegmonous processes dependent upon infection by the *staphylococcus aureus* are best treated by incision and excision of the purulent and infiltrated connective tissues, and tamponade of the wound; disinfection of the surface of the wound is not necessary. The active factor is in converting the closed suppurating process into an open one. If there be an associated grave systemic infection, operation of the local process will be without decided result.

Purely aseptic management of the resultant wound will not prevent superficial suppuration but by continuous contact with an antiseptic it may be kept within bounds. Hence in surgical practice, in the treatment of fresh wounds, strict asepsis is advisable for surgeons as well as for general practitioners; in infected wounds and phlegmonous processes incisions under aseptic precautions, no further irrigation of the wound but tamponade with antiseptic gauze. Only after twenty-four to forty-eight hours' tamponade is a secondary suture possible. He has thus treated all the cases coming under his care in the past two years with the best results.—*Munchener Medicinische Wochenschrift.*

**SYPHILITIC TUMOR OF THE RECTUM SIMULATING A MALIGNANT GROWTH**—Wroczyński was consulted by a man of thirty-two years who had had syphilis at the age of eighteen. After having undergone specific treatment twice he had married; he had a family of three healthy children. He complained of a sense of obstruction in his rectum on defecating. Examination revealed a hard, painless and annular tumor, which was intimately connected with the prostate gland. Dysuria was also noticed. Iodide of potash was administered on the strength of his former history, but the growth continued to increase in size until it completely obstructed the rectum. As the patient had lost eighteen pounds in flesh an inoperable neoplasm of the rectum was diagnosed. Nevertheless, under treatment by mercury the tumor disappeared entirely in six weeks.—*Przeglad Chirurgiczny.*

**HOW TO AVOID SCARS IN OPERATING.**—Beck, in order to prevent resultant scars after operation, advises first to cut a flap of epidermis as in grafting according to Thiersch, with the modification that it is allowed to remain connected with the surrounding skin; this is then turned over, and an incision made in the strip of denuded area. The operation once done, the edges of the wound are united by means of buried catgut sutures, even when the incision is small. The flap of epidermis is then carefully spread over the raw surface. In this manner he has been able to remove enlarged glands, extirpate small tumors, and even operate for torticollis with a scarcely perceptible cicatrix.—*Wiener Medizinische Presse.*

**CURE OF HYDROCELE BY INJECTION OF A WEAK SOLUTION OF MERCURIC BICHLORIDE INTO THE SAC.**—Holmes, in a case of hydrocele in a diabetic patient, after having evacuated the fluid, injected through the canula 45 grains ( $\frac{3}{4}$  fl. oz.) of a 0.2 per cent. solution of mercuric bichloride, in order to irrigate the vaginalis. In spite of all manipulation, it was found impossible to cause the liquid to flow out; the canula was withdrawn and the liquid left in the sac. Complete disappearance of the hydrocele followed. A local reaction similar to that of iodine followed but it was so moderate that it did not prevent the patient from pursuing his occupation.—*La Semaine Medicale.*

**ARGENTIC NITRATE LOCALLY IN HÆMORRHOIDS.**—Schmey, on account of rapid mummification that Dr. Schliep has seen follow local application of a 2 per cent. solution of argentic nitrate to the stump of the umbilical cord, has tried it in hæmorrhoids and anal fissures. He applies a 2 per cent. locally, both to hæmorrhoids and anal fissures, and has obtained brilliant results. It is absolutely painless.—*Allgemeine Medicinische Central Zeitung.*

## GYNAECOLOGY AND OBSTETRICS.

CONDUCTED BY  
GEO. R. SOUTHWICK, M.D.

**INJURIES OF THE STERNO-CLEIDO-MASTOID MUSCLE DURING LABOR.**—Pincus.—At the close of an elaborate study of the subject, the writer arrives at the following conclusions:

Hæmatoma of the sterno-cleido-mastoid was not recognized previous to Diffenbach (1840).

Injuries of this muscle, severe enough to produce noticeable symptoms or disturbance of function, are relatively rare.

Pathological anatomy and clinical symptomatology are two conditions more or less sharply to be differentiated: (a) true hæmatoma (rupture), the inflammation being secondary; and (b) chronic circumscribed and diffuse traumatic myositis (rupture of the muscle). Inflammation is one of the most prominent symptoms.

The determination of the time of the first appearance after labor is important for diagnosis.

The complaint has nothing to do with syphilis; it is of a traumatic origin. Torsion is the most important mechanical cause; then direct force; pressure of the forceps, of the finger, or of the navel cord drawn about the neck over the muscle. Congenital shortening of the muscle and the delicacy of the tender muscle are also causes to be considered. Schultze's method of respiration does not cause it.

The normal mechanism of the injury is clearly defined. In the first position of the vertex the left muscle is injured; in the second the right. In the first position of the breech, the right; in the second, the left.

This injury is of no great forensic importance.

It leads only exceptionally to persistent torticollis (ischæmic contracture, and after extensive traumatic destruction of the muscle).—*Zeitschrift für Geburtshütse und Gynäkologie*, Bd. xxxi., H. 2, 1845.

**MASTITIS—TREATMENT.**—Norris states: The routine management, at the Preston Retreat, of the breasts and nipples is as follows: When the flow of milk appears, each patient wears a Murphy binder, pinned in such a manner as to give support to the breasts, but not to compress them. The infant's mouth before, and the mother's nipples both before and after nursing, are cleansed with a clean cloth and a saturated solution of boric acid. At the first appearance of sore nipples, the latter are kept scrupulously clean, and are covered with a disk of waxed paper upon which is spread a film of paste composed of equal parts of bismuth subnitrate and castor oil with twenty grains of boric acid to the ounce of paste. A glass nipple-shield is used if nursing is very painful. Caked breasts are promptly relieved by massage, combined with a cautious use of the breast-pump. Massage is not used in the interstitial variety of mastitis; this variety can be recognized by the following signs: A gradual rise of temperature following a sore nipple which has refused to heal; a dull pain or aching in the breast, rather than an exquisitely tender spot over an enlarged nodule; early redness and œdema of the skin at a portion of the breast corresponding to the situation of the fissured nipple; and, sometimes, slight enlargement and tenderness of the axillary glands.

—*Am. Gynaecological and Obstet. Journal.*

## OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

CONDUCTED BY  
CHAS. M. THOMAS, M.D.

**THE RELATIVE IMPORTANCE OF LABYRINTHINE AND OCULAR DEFECTS IN THE AETIOLOGY OF VERTIGO.**—Boyer says the purpose of his paper is to discuss briefly the commonly accepted cause of the majority of cases of vertigo met with in practice, and to draw a comparison between it and another cause, and finally to record a few cases of vertigo with the treatment employed for their relief. If the experiments on the semi-circular canals have proved anything, it is that the vertigos with which we are most familiar cannot be caused by labyrinthine irritation. Ten cases are reported, all of which had eye symptoms and one only had disease of the ear. One case, aged 8 years, had vertigo and dizziness until loss of sight, when they disappeared. This patient had atrophy of the optic nerve. The ear case, had, on examination, exophoria of five degrees, for which a tenotomy was done, giving entire relief to vertigo, and correcting the deviation, which continued for several years. Two subsequent operations were done on various muscles with complete relief. Another case, one of exophoria, was entirely relieved by tenotomy.

In conclusion, it will be of interest to remember that heretofore the prognosis in cases of vertigo has habitually been unfavorable.—*Ann. d' Oculistique*, cxiv. No. 5.

**A SAFE AND SURE METHOD OF REDUCING ENLARGED TONSILS.**—In a contribution to the *Journal of the American Medical Association* Dr. H. W. Kendall, of Quincy, Ill., describes a method which he has used with advantage for ten years: “We have an efficient cauterant and at the same time an antiseptic and alterant in pure hydrochloric acid, which is always friendly to human flesh. This is the agent that I have found so efficient in reducing enlarged glands in all parts of the body, but the method of using it is the particular point that I wish to present in this short paper. My method is the use of capillary glass tubes (Bohemian or Whitall & Tatum's glass) one eighth of an inch calibre, heated in a Bunsen flame and drawn to a point, the shaft of the drawn part two inches long, with calibre one-sixty-fourth of an inch, broken off and fire polished. Now, if the shaft of the tube is five inches long the drawn part will hold, after dipping in a fluid, one minim; if the larger shaft is increased in length it will hold more. When the point of this tube touches any substance it will deposit a fraction of the drop; by long contact it will deposit all that it contained.

“I dip these tubes into pure fuming hydrochloric acid and push them into the excretory ducts of the tonsils, three in each gland at each sitting, twice a week. This operation is painless and produces no inflammation or swelling. Five or six applications are sufficient for moderately enlarged glands.”

**THE VALUE OF CREDÉ'S METHOD IN THE PREVENTION OF OPHTHALMORRHEA NEONATORUM.**—R. Köstlin has collected elaborate statistics from the large clinics of Europe and America showing the prevalence of ophthalmorrhea neonatorum before and after the use of Credé's method of dropping 2 per cent. solution of nitrate of silver into the conjunctival sac of new-born babies.

Without prophylactic treatment ophthalmorrhea was present in from 3 to 50 per cent. of the cases confined in the various clinics, the average being about 19 per cent. Since the introduction of Credé's method, 24,724 cases show that the percentage has fallen to 0.5%.

Various attempts have been made to find something to supplant nitrate of silver. Carbolic, which was first used, was discarded on account of bad results.

Bichloride of mercury has been used in something over 20,000 cases, and gives results as good or better than Credé's method, but has the disadvantage of causing considerable irritation. Stratz reports 0.43 per cent. of ophthalmorrhea among 460 cases, while catarrh was present in 1.8 per cent. and irritation in 18.3 per cent.

Irrigation with sterilized water gives results less satisfactory than either nitrate of silver or bichloride of mercury, and the danger of injuring the eye is quite as great as in either of the other methods. Hoffmeyer reports one case of severe corneal ulcer from washing the eye with water.

Trichloride of iodine has been tried in several hundred cases, but gives results even less satisfactory than any of the above methods.

The author thinks that silver nitrate gives the best results of all the methods yet tried, and that it has been used in cases enough to establish its value beyond a doubt. It is so easy of application and harmless in its action that it may be used as a routine by midwives.

Regarding the time of infection, he thinks it takes place during the passage of the head through the parturient canal, and not from material adhering to the eyelids or introduced into the eyes by water during the first bath, and supports his opinion by reporting several cases of prolonged labor in which children were born with well-established ophthalmorrhea. Any method which simply cleans or disinfects the eyelids at the time of birth is not scientific, and is bound to give poor results.

The disadvantages of Credé's method are very unimportant. Corneal affections are not observed, and irritation is seen less often than with other methods. The eyes are not rendered especially liable to a late infection, and when a late infection does occur, it usually means that the infection was already present in the eyes, but development of the germs was retarded by the silver nitrate.—*Archiv. für Gynäkol.*, L. No. 2, p. 27.

**SYRINGING IN LACHRYMAL DISEASE.**—Dr. William H. Bates read a paper on this subject. He said that the method of syringing for the treatment of lachrymal disease was not only painless, but effective. In cases suitable for this treatment the swelling, redness and pain subsided in a few days. In a chronic case benefit was felt after the first treatment. The treatment was applicable to cases of acute catarrhal and acute purulent inflammation of the sac, phlegmonous inflammation of the sac, blennorrhea of the lachrymal passage, and lachrymal fistula. It had failed to cure some cases of syphilitic and inflammatory stricture and some catarral cases. The reason syringing was so effective was that not only was septic material washed away, but, on the subsidence of the inflammation of the mucous membrane, the duct opened and drainage was established. The syringe he employed was an ordinary eye-dropper, with a very fine tip bent at right angles to the stem. The tip of this instrument was usually inserted in the lower punctum. Occasionally, where large quantities of fluid must be used, a piston syringe would be required. A glass syringe was not only cleanly, but it enabled the operator to see whether or not the fluid actually entered the lachrymal canal. When solutions of nitrate of silver were used, they sometimes obstructed the tip of the syringe. When this occurred the obstruction could be easily removed by immersing the tip in a solution of iodide of potassium. To make the injection into the lachrymal sac, the operator sits in front of the patient and light is reflected on the part by a mirror. The patient looks upward and outward, and a piece of cotton is placed over the semi-lunar fold and held there by the forefinger with slight pressure against the upper punctum. The thumb everts the lid and exposes the punctum. The tip of the syringe is then inserted into the punctum, and the syringe is held parallel to the conjunctiva. In some cases there is a tremulous motion of the lids, which makes it difficult to insert and keep the tip of the syringe in place. Cocaine does not always help us with very nervous patients—an appeal to their self-control often accomplishes more. In some cases it might be easier to make the injection through the upper punctum. The syringing should be continued until the fluid came away clear, and the quantity used might be as much as a pint. Chronic cases usually required several months for a cure. The speaker said he had used simple water more than any other fluid for this syringing, although sometimes a little salt had been dissolved in the water to make it less irritating. Experiments had been made with various oils, but all of them caused irritation, and were found to have no advantage over water. In exceptional cases astringents were useful, the strength varying from 5 grn. to the ounce up to a saturated solution in a few cases. As a rule, the weaker solutions were more satisfactory. It could not be demonstrated that antiseptic solutions were any better than ordinary water—indeed, the antiseptic solutions irritated the parts, and, by causing swelling of the mucous membrane, obstructed drainage. The mere fact of being able to thoroughly syringe out the passage proved the absence of a stricture. In the treatment of these cases he had found it necessary to use the water often and in large quantities. To have the water forced under the eyelids was a disagreeable accident, but no harm had been observed from it. Where there was much bleeding after the operation, or after probing, it was much more easily controlled by peroxide of hydrogen than by hot water.—*Amer. Med. and Surg. Bulletin*, March, 1896.

## MONTHLY RETROSPECT OF HOMOEOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D.,  
FRANK H. PRITCHARD, M.D., AND F. MORTIMER LAWRENCE, M.D.

**ANTIPIRIN IN URTICARIA.**—Dr. Alexander Croucher reports the case of a female infant, aged 12 months, which had been staying in the country, and was bitten by some insect, causing a good deal of irritation and an eruption of papules. This was relieved by the application of diluted acetic acid. Vaccination was then performed. Two days later the child was covered with an urticarial rash, aggravated at night, and total inability to sleep was a result. *Chamomilla 3x* and *mercur. sol. 3x* failed to give any relief. Remembering that he had somewhere seen *antipyrin* recommended for nettle-rash, Dr. Croucher prescribed *antipyrin*, gr.  $\frac{1}{2}$ , in a teaspoonful of water three times a day. The mother said that the first dose relieved, and the rash, which had lasted four days, disappeared, and has not returned since. There have been numerous cases reported in the medical journals where *antipyrin* has caused erythematous and urticarial eruptions, and it was satisfactory to be able to relieve a similar disease with a remedy that has caused it. The child was quite healthy otherwise.—*Monthly Hom. Review*, March 2, 1896.

**LOBELIA IN INFANTILE COLIC.**—In the *Eclectic Medical Journal* Dr. Holton writes as follows :

On his subsequent visits to obstetrical cases, the doctor is often called to relieve the infant of what the nurse calls colic. The baby cries and kicks and squirms incessantly, giving no rest to any one in the house. After a careful inspection, to see that no mechanical cause is doing the mischief—such as pins, chafing of clothing, etc.—put one drop of specific lobelia in an ounce of water; give one-half teaspoonful, warm, to the infant. It will be in a quiet sleep in five minutes. Any return of the trouble will yield to one or two doses. I have used this for many years, and never knew it to fail in any case where the above conditions were present.

**SOME VERIFIED INDICATIONS.**—In the *N. A. Journal of Homœopathy* (April, 1896) there are reported the following verified indications for the selection of remedies in various affections of children :

*Constipation*—*Silicea*.—Difficult expulsion of even soft stools; where the child's head and face perspire copiously *directly upon its falling asleep*.

*Euphrasia*.—Stools delayed and scanty, in hard, dry balls, almost fissuring the anus. Sleep disturbed by frequent waking, as if from fright.

*Enuresis*—*Equisetum*.—Patient wets bed every night, and *dreams of seeing crowds of people*.

*Exzema of Scalp*—*Arsenic*.—Dry, scaly eruption on scalp, often extending over other portions of skin; great restlessness, especially after midnight; emaciation and debility.

*Cale carb.*.—Leucophlegmatic children, with thick crusts on scalp, covering a quantity of pus.

*Graph.*.—Scalp exudes clear, gelatinous fluid, forming loose scales or scabs, which fall and leave surface raw and moist, other scabs forming and falling off in like manner. The most characteristic seat for the eruption is behind the ear, and in this connection *graph.* concurs with *hepar sulphur*. The *graphite* patient is perfectly indifferent to touch, while *hepar* is very sensitive to touch, even in places on the head remote from the eruption.

**ANTIPYRIN IN COLLAPSE.**—In the *Indian Homeopathic Review* (November, 1895) Dr. Bhaduri writes.

"Some time ago I saw Dr. Salzer save a cholera patient from imminent death by antipyrin. Since then, when carbo v. fails to bring back the pulse of a collapsed cholera case—the symptoms not corresponding to any other known medicine—I generally give the medicine in the sixth decimal potency, and I must acknowledge that I have saved many a patient from death by its timely use. In the case of a girl I gave it with success. She had also that difficulty of breathing of which I wrote in a former issue. The difficulty of breathing also disappeared. Remembering that it also produces coagulation of blood in the heart, it is very desirable that every homœopath should try it in such cases. The principal symptoms in which I have found it useful are: 1st. Continual cold and clammy sweat, with a sinking of the pulse, with long sighing breathing at intervals, the intervals gradually decreasing; burning sensation all over the body and some restlessness. 2d. I have applied it in cases of collapse during the defervescence of fever, specially malarious, with very high temperature, with marked success. 3d. I gave it in a case of consumption, with fever, when the patient had lost all her vitality and was reduced to a mere skeleton; I gave her first bryonia, then arsenic and then antimony. She was relieved of all her troubles; she was really far better, as she herself told me and all her relatives, but as her fever began to decrease, collapse set in. It seemed to me it was the energy of fever which kept her alive, and when the fever disappeared, she could not be propped up. I gave her carbo, which brought back the pulse for a time, but could not keep it up. Then I gave her antipyrin 6th; the effect was miraculous, and brought back the pulse and kept it up for a long time. Had she been a little stronger, I believe she would have been saved by antipyrin. This application of antipyrin is thoroughly homœopathic.

**RHODODENDRON IN CHRONIC RHEUMATISM.**—Dr. A. M. Cash reports the case of a woman aged 75, who was a martyr to rheumatism for many years. Her hands were much deformed, fingers crippled and joints swelled. Her chief complaint was of obstinate gnawing pain in the stomach which was very distressing. She had hot acid heartburn and eructations; severe gnawing pain in the loins and lower limbs down to the toes; and often felt as if a cold wet sheet were round her, and was always very chilly. The urine was copious and clear. *Kali bich.* effected little. She had heavy sweats at night which did not relieve pain. *Merc. dulc.* gave her some relief, but the pain returned "as if bones were gnawed." He prescribed *rholodendron*, 1x, gtt. v. ter die. In a few days the pain and acidity were relieved, and she rapidly became much better, and a month later was still keeping so.—*Monthly Hom. Review*, March 2, 1896.

**HEAD SYMPTOMS OF GRAPHITES.**—Dr. Washington Epps notes the following symptoms as occurring about the tenth day on three separate occasions, in a male aged 24, who was taking *graphites* 2x and 3x in 3 grain doses night and morning, for psoriasis unguis. The symptoms would disappear in a few days with *china* 1x. The patient described the pain as "an intense, heavy weight, or dull pressure, in the upper part of the occiput, with a feeling as if the head were drawn back and the neck would break, obliging him to rest his head." While the pain lasted he was quite unable to read or work.—*Monthly Hom. Review*, March 2, 1896.

**HARD WATER IN CONSTIPATION.**—Dr. Washington Epps records a case which is interesting from the five weeks' duration of complete stoppage of the bowels and the prompt action of hard water. A boy, aged four years, in general appearance healthy, had suffered from constipation all his life. When first seen in May, 1877, the bowels were acting every fourteen to twenty one days, the stool being in small, round, very dark pieces. There was often inclination, even to a dozen times a day, without result. The patient looked dull about the eyes. In May and June, the boy went for thirty-five days without any action. On the fourteenth day he dropped little pieces of his motions as he played about, and he had frequent inclinations. He continued perfectly well, eating and drinking as usual until the thirtieth day, when he vomited his food four times. On the thirtieth day of stoppage the father gave an enema, which brought away a large quantity of faeces, and the child was quite well again. In July and August the boy went with his father to the Convalescent Hospital, Eastbourne. Whilst there the father and most of the other patients suffered from most obstinate constipation, caused by the chalky water, and had to take the usual daily pill. The boy had a

natural relief of the bowels each day during the visit. On returning to London, the constipation gradually returned until there was an action only once a week, then fortnightly. The boy was eventually cured by being allowed to eat six to twelve oranges a day; his bowels then acted every four or five days. The remedies given, but without result, were opium, lycopodium, nux vomica, plumb. acet., calc. carb., and veratrum album., in the above order.—*Monthly Hom. Review*, March 2, 1891.

**SULPHUR IN DIARRHOEA.**—Dr. H. S. Hathaway reports the case of a child 7 months old. Diarrhoea for four days; ten to twelve movements a day; child cachectic. Pathogenetic symptoms: Stool semi-fluid, frequent, copious, yellowish-green, very offensive, fetid; patient's skin smells bad; dry cough; rattling of mucus in the trachea. Sulphur 3 given for three days; marked improvement after the first dose. Five days later all the symptoms were cured and the child was much improved in general appearance.—*N. A. Journal of Homœopathy*, February, 1891.

**ARNICA IN DIARRHOEA.**—Dr. H. S. Hathaway records the case of a female patient, *æt.* 4, cutting last molar tooth; usually a well child. Pathogenetic symptoms: Stools thin, brown, frequent, involuntary; sensitiveness of the abdomen; must lie down after every stool; aching in the teeth. Arnica 3 was given every hour for one day; only one movement during that time; all symptoms cured except pain in the teeth.—*N. A. Journal of Homœopathy*, February, 1891.

**ARSENICUM IN PSORIASIS.**—Dr. W. S. Mills records the case of Mrs. X., *æt.* 28, married several years, no children. Had an eruption similar to the present one six years ago, which gradually disappeared. Eruption has been present now for one month. Has been under old-school treatment, using lotions and ointments externally. Eruption spreading, and the symptoms have been aggravated. Pathogenetic symptoms: The eruption is red, dry, covered with fine scales like scarlet fever desquamation, with intense itching, worse at night. Clinical symptoms: Eruption began on the right shoulder, then spread over to the left shoulder, about the waist, and on the thighs. On February 24th prescribed *rhus tox.*, with no benefit. On the 25th gave *arsenicum* 3. On March 6th the patient is better and the eruption disappearing. Continued the *arsenicum*. She reported an entire cure after a few days. Over a year now, and there has been no return of the eruption.—*N. A. Journal of Homœopathy*, February, 1891.

**THE THERAPEUTICS OF MAMMARY ABSCESS.**—Dr. William C. Richardson suggests, in connection with the surgical treatment, the following remedies:

**Belladonna.**—When the breasts feel heavy, are very hard, and the redness runs in radii, accompanied with pulsating pains, high fever, headache over the eyes, constipation and scanty urine.

**Bryonia.**—Stone-like hardness of the breasts, which are hot, painful, but not very red; great stitching pains in the breast, worse from the slightest motion.

**Graphites.**—In old cases, where there are so many old cicatrices from former ulcerations that the milk can scarcely flow.

**Hepar Sulph.**—When suppuration seems inevitable.

**Lachesis.**—When the breast has a bluish or purplish appearance; lancinating pains in the mammae; pains down the arms.

**Mercurius.**—Especially if transient chills or throbbing indicate the probable formation of matter; also in cases where suppuration takes places in different parts of the breast.

**Phosphorus.**—Phlegmonous inflammation; breast swollen; red in spots or streaks; hard knots in different places, with fistulous openings, with burning, stinging and watery offensive discharge.

**Phytourea.**—“Gathered breasts,” with large fistulous, gaping and angry ulcers, discharging a watery, fetid pus. In ordinary caked breasts it is called specific.

**Silicea.**—In cases where *phosphorus* is not sufficient to heal the fistulous opening, with callous edges; or to disperse the hard lumps in the breast; or where the discharge is serous.

**Sulphur.**—Suppuration of the mammae, with chilliness in the forenoon, heat in the afternoon.—*St. Louis Journal of Homœopathy*.

**THE MEDICAL TREATMENT OF REFLEX SPASMS.**—According to Dr. James T. Martin, the first and most important remedy in most any case of abdominal irritation is *cina*. It is the children's remedy. Given with the proper indications,

it acts with great celerity. When it is indicated, the sleep will be restless, the child will wake startled or in a fright many times during the night; much like *belladonna*, with this difference: The *cina* patient jumps up in a fright, and it takes him some time to know what he is about or to really get awake; the mother will tell you that she has frequently to shake the child quite hard before he will really awaken, while the *belladonna* patient is wide awake the instant the fright comes. With *cina* it seems to come as a dream, while with *belladonna* the cause seems external. Usually the *cina* patient frets all day, while the *belladonna* patient sleeps or is drowsy. With either remedy there may be nausea and vomiting, while *cina* may at the same time have a frothy, fetid, yellow diarrhoea, with pain in the abdomen. He will be peevish and restless, and not disposed to be satisfied with what is done for him, picks his nose, or, if a very young child, rubs it very often. He will frequently turn white around the mouth, while at the same time the cheeks (one or both) may be very red.

*Belladonna* is the next remedy in importance to *cina*. The fever will be very high and does not rise and fall so suddenly as is often the case with the *cina* patient; the child sleeps a good deal more than ordinary. The least noise, especially an unusual noise, will startle the child and likely cause it to awake suddenly from sleep. The fever will last all day and most of the night, and longer if not relieved. There may or may not be nausea and vomiting, pupils of the eyes widely dilated, conjunctiva injected, and there will likely be some trouble swallowing.

*Nux vomica* is a very important remedy in these conditions. The class of cases to which it is more especially adapted have their origin in dietetic irregularities. The child for some time before the seizure will complain that the food hurts it immediately after having eaten. It is exceedingly cross and wilful, disposed to fight rather than whine. It is troubled with constipation, with frequent and ineffectual desire for stool.

*Chamomilla* with the laity is a panacea for most everything, but its sphere of action is much more limited in this class of cases than either of the other remedies mentioned, for the simple reason that it is more frequently indicated in a diarrhoeic condition of the bowels than when there is constipation or obstruction. When indicated the child will be fretful, desires to be carried all the time, and really seems better when carried. The diarrhoea is usually green, with white, curdled, undigested pieces mixed with it, and is aggravated at night. The child has a poor appetite, and is not disposed to be friendly with attendants.

*Culcarea carb.* is a very useful remedy, supplementary to *belladonna*, after the acute stage has passed away, should *belladonna* not cure entirely. The child will perspire about the head very profusely. Its feet will be cold and damp and the abdomen very large in proportion to the child. The child usually has a very poor appetite, or it may have a very good appetite and be very poorly nourished. Stools white and chalky.

*Sulphur, bryonia, hyoscyamus, mercurius, podophyllum* and many others may be indicated in this trouble, but the ones given above are indicated more frequently than all the others. In the discussion of these remedies nothing is said about the symptoms during the spasm, because they are of the least importance to the prescriber, inasmuch as a second spasm is not likely to occur as long as the child has proper food and yet he may be ailing or in poor health until he receives proper medical treatment. Such cases will necessarily have to have close supervision of their diet until such a time as they are old enough to select for themselves foods that are not injurious.—*Hom. Journal of Obstetrics, Gynaecology and Paedology.*

**THE TREATMENT OF INSOMNIA.**—Dr. J. Martine Kershaw suggests change of climate and surroundings, the use of electricity, hot hip baths, and, if there be hepatic or intestinal torpor, rectal injections of hot water. The diet should be regulated. All food should be masticated well and slowly. Most nervous people drink too little water. Stimulants, tobacco, coffee and tea should be abstained from by most sleepless people. *Nux* cures most cases due to worry, abuse of alcohol, tobacco and coffee, or cases due to dyspepsia and constipation. *Belladonna* has few superiors as a remedy for hyperemia of central origin. He has relieved a number of cases due to grief with *ignatia*. *Mercury* is to be thought of when there is a history of syphilis; *china* when the patient is anemic. Some cases are due entirely to the presence of a tape worm; it should be removed. He has known *aranea diadema* to induce quiet sleep in a number of obstinate cases, and *panxiflora incarnata* has served him well in a number of bad cases.—*St. Louis Journal of Homœopathy.*





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## THE PRESENT STATUS OF THE HOMEOPATHIC MATERIA MEDICA.

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IN undertaking to discuss this subject, it is with no expectation of meeting a sympathetic audience, as the aspect in which it is aimed to present it is not the one commonly held by the school. The purpose here is to attempt to show how our theory may be made to keep pace with our practice, and to indicate the manner in which the subject should be approached for a clearer understanding of its value and its limitations.

When a client retains an attorney, either to defend an action against himself or to bring an action against another, he is apt to be told at the outset to state his case in its worst possible aspect, that his attorney may know just what to expect from his adversary. In the discussion now being inaugurated, it is our first duty to free ourselves from all sentiment and all prejudice, and endeavor to understand just how much a candid, disinterested, and practical mind would be able to make of our case, were it presented to him to defend on the basis of the facts.

The general interest recently awakened in our *materia medica*, and the articles constantly appearing as to how it should be studied, how it should be taught, and what can be done to improve it, are full of evidence of the wide-spread and deep-

rooted anxiety on the part of its advanced students and teachers concerning the continually decreasing interest and growing skepticism of the beginning students, and many practitioners, in this subject. It may be said that the future of Homœopathy itself is dependent upon our ability to shed fresh light upon it. Whence comes this unrest?

The reasons may be stated as two-fold, one negative the other positive. On the one hand, the rapid increase in knowledge of the ætiology, course, diagnosis and prognosis of disease in general; the prevailing skepticism in the leading minds of the old school regarding the treatment of diseases by drugs; the rapid introduction of antipyretics, analgesics, lymphs, serums, etc., making what prescribing is done apparently easy, simple, and positive; the great strides in the art of surgery, almost totally divorcing it from that of medicine, and the including within its domain a large class of affections heretofore regarded as the proper subjects of medical treatment; the introduction of endless preparations made, advertised, and distributed by the manufacturing chemist to render the road of the practitioner easy; and last, but not least, the enormous development of the specialties, and the devotion of many of the best minds of our school to them, have had a powerful and degenerating effect upon the minds of both old and young in our school regarding the specific treatment of disease by drugs.

On the other hand, and in striking contrast to the above, stands the almost unlimited number of homœopathic remedies, with an even more unlimited, uncertain, indefinite and frequently overlapping symptomatology, often of reputed unreliability, together with their intrinsically difficult and laborious application at the bedside.

It is with this second and positive reason that we are especially concerned. What, then, in the plainest language, is our *materia medica*? Briefly, it may be asserted to be a collection of statements true and false (not intentionally, but mistakenly false), of objective effects and more largely subjective sensations alleged to have been seen and felt by persons as the result of the accidental or intentional use of drugs, crude and attenuated. So far as the symptoms themselves are concerned, this is about all the personal knowledge the physician can have of them, except in the limited sense in which he may have expe-

rienced some of them himself as a prover or the involuntary victim of a poisoning. It is practically impossible for him to reproduce them under the conditions in which they were originally produced, or under fresh conditions, for his own personal conviction and satisfaction. They stand before him as complex statements which he cannot prove or disprove for himself. He can read them—*i.e.*, hear them—but he cannot see them, smell them, taste them nor feel them, nor can he measure or weigh them; so that as actual objects of knowledge, he has the least possible experience with them. They enter so little into intimate association with the common experiences of his consciousness as to rarely become objects of positive knowledge with him. In themselves they constitute knowledge of the lowest order—*i.e.*, ununified knowledge. Even after years of contact with them, they do not become incorporated into the very fibre of his brain as they should. Therefore, as a result of all this, the physician's relation to the symptomatology is more one of sentiment and belief than of actual positive knowledge.

Independent of the confusion of mind occasioned by the large number of remedies and larger number of symptoms under each, and our necessarily incomplete knowledge of them—owing to their intrinsic feebleness as mental stimuli, due to their peculiar position as objects of knowledge—we have also to contend with their so often apparent, individual want of agreement, each remedy almost always presenting so many varieties and variations of practically the same symptom, and their still more frequent parallel in other remedies, as to create a condition in which almost as fast as one mental impression is made it is annulled or cancelled by another.

As further illustrating this particular phase of the subject—namely, the symptomatology as an object of mind—it is only necessary to refer to the difficulties encountered in studying and retaining it. After years of work in our studies and years of application at the bedside, the best of us find our knowledge continually slipping away from us—new facts and new experience rather displacing the old than adding materially to our common store. We are in the position of a person storing his meal in a receptacle with a hole in it, from which it is continually leaking, and if it is not constantly regathered or entirely

already be some models to which to point among so many, even as the result of accident.

It seems that the difficulties are fundamental and inherent in the very nature of the subject-matter itself. Careful thought must lead to the conclusion that the subject-matter of the homœopathic *materia medica* must always be more relative than absolute, and that we must always be in possession of a *materia medica* giving us relatively much positive knowledge, that is considering the nature of the subject, and much more negative knowledge only to be filled out and rounded up by inductive methods and long and careful clinical experience.

While reprovings would undoubtedly add much to our positive knowledge, they would also enormously augment the negative element. When we consider the varying conditions on the part of the drug as comprehended in poisonous and lethal doses, varying doses of the crude or tincture within safe limits, and the whole gamut of the lower potencies on the one hand, and the varying elements on the part of the voluntary or involuntary prover as comprehended in differences in age, sex, social condition and idiosyncasy on the other hand, it becomes probable that no single experiment can be absolutely duplicated, and that many hundreds would have to be made in order to arrive at a satisfactory degree of unity, and in the meantime the ununified elements would be increasing by the hundredfold conditions even almost beyond the resources of a large and vigorous school of medicine. Had we not better perhaps stop and seriously ask ourselves with what we are dealing, and if the material already at hand does not at least give us a clue to what lays hidden, to be developed and uncovered by clinical work? In other words, does any knowledge we already possess give reason to hope that new provings and new studies would enable us to get much more out of the remedies than we now get, or is it probable that we already get as much as the circumstances justify us in expecting?

What evidence is there of the positiveness or truth of a symptom individually or a proving collectively? The repetition of the sense or significance of a symptom in two or more provers may be taken as presumptive evidence of its genuineness, but it is not proof, and conversely the occurrence of a symptom in a single prover is not, in any sense, even presum-

tive evidence of its un genuineness, much less proof. The idea that number furnishes any conclusive evidence upon this question should be abandoned as unscientific and even illogical, in view of the homœopathic standpoint that no element in a patient or a proving is too small to merit attention. If number has any value in establishing its own truth it should at least have equal value in establishing the truth of the entire proving of which it is a part. In addition to number as evidence of truth, we also have a fidelity to nature as we have, each one of us individually, experienced it at the bedside, and the final use we may be able to make of it clinically, and even this is not positive, as it only decides in a negative way one element of the problem. One man or one set of men can not decide this question arbitrarily; it must be decided each one for himself according to his individual judgment and experience.

The proposition is here advanced that truth, positiveness or genuineness is not necessarily synonymous with reliability or value. A symptom or a proving may be true without being reliable or valuable. Reliability or value is dependent upon a symptom, or proving, similarity to some manifestation of disease. It is a self-evident fact that the pathogeneses of drugs and the symptomatology of disease are in their fundamental nature quite unlike, however similar the superficial resemblance, this unlikeness being fully comprehended in the homœopathic law of cure, similar meaning a resemblance in unlike things. This is made clearer by stating that in the pathogeneses of drugs there are many symptoms, undoubtedly genuine, having no corresponding symptomatology in disease, and conversely there are diseases having no corresponding symptomatology in the pathogeneses of our drugs, and it is only when they approach each other, or in other words as they are similar, in harmony with the homœopathic law, that we are likely to find a curative relation. If these statements approximate the truth then it becomes apparent that even absolute certainty of a symptom's genuineness does not necessarily make it available in the treatment of disease.

In this connection it is to be borne in mind that in the whole range of drug pathogenesis there are perhaps very few individual complete pictures of the symptomatology of any disease in its entirety, but rather only incomplete pictures of the indi-

vidual stages or features of the disease. As a result of this almost every disease is treated by many drugs changing from day to day or hour to hour as the disease advances, retreats or fails to move in either direction as the result of the first selection.

A few words concerning the *Law* itself. Without stopping to define it here, we will first consider its material and methods. In the first place it acts with a specific agent, the drug; but inasmuch as it acts with indefinite and unspecified doses of the crude drug or tincture, through the entire gamut of potencies, it is a most indefinite agent. In the second place it acts upon a specific object, the animal man; but inasmuch as it acts upon man in every conceivable variety of age, sex, social state and idiosyncrasy, and in every conceivable variety of disturbed function and altered tissue, congenital and acquired, it acts upon a most indefinite object. And thirdly, it aims at a relatively specific result, either amelioration or cure, according to circumstances; but the way it aims to accomplish this result is most indefinite in keeping with the indefiniteness and variability of the symptoms and lesions for which it may be prescribed.

An element of uncertainty and difficulty is inherent in the application of the law itself. The idea of similarity on a superficial consideration seems like a comparatively simple problem; but when it is more thoroughly considered and contrasted with the idea of identity it becomes much more complex. It means, of course, a resemblance in things dissimilar, *i.e.*, a resemblance on the part of the symptomatology of drugs to the symptomatology of disease, a resemblance extending from the greatest similarity conceivable in dissimilar things to the least. There is no common or medium ground from which, on the one hand, it is too great, or on the other, too little. It embodies, in a scientific sense, the greatest weakness of homœopathy, and in a practical sense all of its great and far-reaching power. Scientifically it is weak, because it is difficult to comprehend the fixing of hard and fast lines in the conception of the idea of a resemblance in things dissimilar. As a matter of fact, it includes, primarily, a resemblance on the part of the drug to the totality of the symptoms of the patient, not alone of the disease, *i.e.*, the pathognomonic symptoms of the disease, their peculiar and individual symptoms, as well as the

idiosyncratic symptoms of the patient *per se*, organic and inorganic; under other conditions it comprehends only those symptoms which are pathognomonic of the disease; and, again, only those symptoms which are individual and peculiar to the disease, ignoring its pathognomonic signs; or only those symptoms, organic or inorganic (idiosyncratic), peculiar to the patient, regardless of the symptoms of the disease itself, pathognomonic or peculiar; and, finally, we hear of similarity by the sequential relationship of drugs to the sequential relationship of disease. In the very nature of the case it is hard to conceive how it could be otherwise; one has got to be content and take what he can get, and a cursory glance at homœopathic literature will convince any one that the only standard exacted is success; in other words, a successful result will justify any so-called homœopathic prescription.

So we see that at its most vital point the conditions are favorable to the widest possible divergence of individual opinion; any half dozen persons may have as many individual conceptions of the law, a state of affairs fatal to a scientific conception; while at the same time this wide divergence of opinion makes possible the great strength and lasting vitality of the law, as it permits it to be so elastic and so comprehensive as almost to include within its domain every conceivable condition of drug therapeutics, even embracing and translating into the language of drugs the clinical features and symptoms of disease, the idiosyncratic symptoms of patients, and even their peculiar congenital organic habits of body and mind, which, in any attempted scientific interpretation of it, must necessarily be absolutely excluded.

There are two other points concerning the application of the law calling for attention. The first is the dogma, largely, if not universally held, that every complex of symptoms of disease has its homœopathic counterpart, or curative agent in some particular drug pathogenesis and in no other, and for its removal this particular drug is indispensable. That when a cure does not result the proper remedy has not been found, but that it exists, and all that is necessary is a sufficiently diligent search. This idea undoubtedly has its origin in the once prevalent view that an all-wise Providence created disease for some inscrutable purpose and also created drugs for their re-

moval, and comprehends the assumption of a natural relation between drugs and disease, and the universality of this relation. In contrast with this view it seems a self-evident fact that the nature of the effects of all drugs, with possible exception, differ from each other rather in degree than in kind, while the effects of various diseases differ from each other rather in kind than in degree, and that the collective or individual effects of drugs are fundamentally different from the collective or individual effects of diseases, and that many of the properties of drugs do influence many of the manifestations of disease, but that there are diseases and manifestations of disease uninfluenced by drugs, or uninfluenced so far as the experienced physician can see. From this it also follows that there are diseases and features of disease having their counterpart in a number of drugs, any one of which will give almost equal results. In some departments of the physician's work he is confronted with an embarrassing richness of curative material, in others with an apparently sufficient, but often disappointing material, and again with an absolutely inadequate or disappointing material, and he finds consolation only in the fact that in the nature of the case he should expect nothing else, both on account of the nature of the disease and the indefinite and uncertain curative action of drugs in general.

The other condition frequently insisted on is that some one definite drug manifestation is absolutely indispensable on the part of the patient in order to make possible any curative action regardless of its plain indication by other symptoms or conditions as illustrated by the anxiety and restlessness of aconite, anguish, debility, burning pains of arsenic. It is not maintained that they are not valuable guides when present, but that they are often absent, and the drug may be plainly indicated without them. It does happen, and not infrequently, that plainly, sometimes apparently absolutely indicated drugs fail, when some less apparently indicated drug will be substituted and yield results varying from indifferent to brilliant.

In bringing this paper to a close, it is fitting to do so with a brief consideration of the definition of a cure. In a scholarly paper published in the HAHNEMANNIAN for June, 1895, Pemberton Dudley defines a cure as "a change from disease to health, caused by artificial means." And "A homœo-

pathic cure is a change from disease to health caused by the action of the ‘similar’ drug directly upon the vital activity whose disorder causes and maintains the symptoms.” Elsewhere he further limits these definitions as follows: “Moreover, if the change from disease to health is merely rendered possible, or if it be merely encouraged or promoted by the treatment employed, yet not actually determined or caused by it, the phenomenon cannot be properly called a cure.” These citations are not made for the purpose of criticism, but rather as an example of the conservative theoretical views of the school, regardless of the actual facts in practice.

It is expected that it will be made clear, from what follows, that a “cure,” technically speaking, forms a very small part of the physician’s work. For the sake of argument, it may be assumed that his work can be divided into three classes: The first, a very large class of so-called self-limited diseases; a second small class of incurable ones; and a third, also small, class of diseases regarding which it may be assumed that they are not self-limited; i.e., they do not tend to spontaneous recovery, nor, untreated, do they tend to end in death. What percentage each of these classes occupies in practice it is not possible to say, but it may be assumed, as an average not too far out of the way, that the last two classes are about equal to each other, and that, together, they are equal to, or less than equal to, the first. The large majority of the self-limited diseases would recover under a pure expectancy; a small percentage will die under any circumstances; others will come more or less close to the dead-line, some, perhaps, actually pressing against it without going over. It is unnecessary to specify the physician’s usefulness in ameliorating suffering and shortening the time of sickness in this class of disease further than to say that it may happen in individual cases that have approached the dead-line, or even pressed against it, that the drug may be credited with rendering recovery possible by merely having encouraged or promoted it, yet not having actually determined or caused it; yet it is not possible to speak of a cure technically. Yet, practically, this suffices to establish the utility of the drug and justifies its publication as a cure, and was, perhaps, all any one could have expected of it.

In incurable cases, euthanasia and amelioration or mitiga-

tion of suffering leading up to it is one of homœopathy's chief claims. Now in regard to the last class (I am not asserting the absolute existence of this class), what does experience teach? It teaches that they are as often treated unsuccessfully as successfully; and when treated successfully by drugs alone, the cure is always tainted by the fact that it is not easy to conceive of an affection capable of a cure by a drug that is not also capable of a spontaneous or accidental cure. It is to be borne in mind that the results aimed at and attained by drugs, whether cure or amelioration, in any and every class of affections do not differ in kind but in degree, and the difference between what may be called a cure and no result, or no appreciable result, is only a difference of degree, and it is probable that quite as often as otherwise instances of change from disease to health, by drugs, is merely rendered possible or merely encouraged or promoted by them, rather than actually determined or caused by them. Therefore, if a definition of a cure is to be undertaken in keeping with the actual facts in practice, it will be necessary to make it so elastic and so comprehensive as to deprive it of all technical or scientific value. It is not unfair to conclude that the profitable utility of the homœopathic drug, from the cradle to the grave, is not to be disputed, yet there is hardly anywhere we can speak of a cure by its means alone, and all efforts to define a cure concisely must be fruitless.

Is it then any wonder that the student, on assuming the cares of practice, turns from a subject in disgust from which he has been taught in the class-room to expect so much, which was to meet every emergency of a medical practice, and from which, in the ignorance of his early and uncounselled experience, he derives so little. Not because the help is not there, as far as the nature of the case justifies the thoughtful and experienced physician in expecting it, but because he, in his ignorance and misconception of false teaching, is unable to extract it from the labyrinth of conflicting conditions and limitations in which the subject is necessarily involved. It is no plain road, and when one has been told that the direction is blazed in plain language on every turn and every crossing, only to find that the oldest and most experienced traveller is frequently in doubt and often loses his way, it is not to be wondered that he sometimes takes to the fields, in doubt that there is any path at all.

It is the duty of our school, regardless of where it may seem to lead, to square its theory with the actual facts of careful and conservative practice. If the school is to retain the prestige it has already gained, it must do this. It must teach its students, in accordance with the facts in practice, the nature of their tools and the character of the material upon which they are to be used, rather understating than overstating the case to them. The balance between theory and practice must ever be maintained, for when they diverge too much the mind is bound to revolt from one or the other.

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### CARBO VEGETABILIS.

BY T. H. CARMICHAEL, M.D., PHILADELPHIA.

(Read before the Homeopathic Medical Society of the County of Philadelphia.)

WITHOUT claiming to present anything that is new, nevertheless it is in the spirit of scientific inquiry that I submit for your consideration a short study of this long-used remedy.

Vegetable charcoal is a composite product of the destructive distillation of wood. It is composed of CHON, ash and hygroscopic moisture. The ash contains potassium carbonate, silica, lime and oxide of iron. It is a great deodorizer, but according to Ringer it has never been determined whether this property depends upon the fact that it condenses gases in its pores or that the oxygen thus condensed and accumulated combines with the other gases with which it comes in contact and thus breaks them up with destruction of their bad odors. Farrington, however, claimed that this property probably resided in the molecules because it is manifested in the potentized state. These properties of absorbent and deodorizer which constitute it an anti-putrefactive about measure the use of the remedy in old-school therapeutics. For the purpose of cleaning out foul ulcers the charcoal poultice has been a favorite expedient. In some diseases of the stomach, such as an ulceration or the varied conditions that seem to be the result of fermentation, charcoal is frequently very useful. According to Ringer, it is especially indicated by the enormous production of wind, irrespective of

other symptoms which prevail among middle-aged women at the change of life. Flatulence is thus a key-note to its use in the crude dosage of the old school and we shall find it to be one of the chief symptoms under the refined posology of Hahnemann.

When we turn from the meagre uses to which charcoal is limited in old-school therapeutics, to its wonderful elaboration through the genius of Hahnemann, we are at first amazed and then, it may be, incredulous. That an inactive agent like vegetable charcoal triturated with milk sugar until a grain was subdivided into a million parts and this administered to healthy people, should produce the 720 symptoms recorded in the *Materia Medica Pura* with the subsequent 469 symptoms in the *Chronic Diseases*, may well challenge careful investigation. Fortunately a reproving of the remedy was conducted by Dr. Conrad Wesselhoeft, and recorded in the American Institute *Transactions* for 1877. This was made by nineteen persons with triturations ranging from the first to the third. The result was 190 symptoms which Wesselhoeft says may be relied upon as genuine. The provers had reported 325 symptoms, so that about 41 per cent. was rejected. If we may apply this percentage to Hahnemann's provings the number of symptoms would be reduced from 1189 to 703 and it is probable that they should be still further cut down, since at least 930 of these were reported by only four persons and there are many instances of the frequent repetition of symptoms that were apparently the same and which should be considered as one.

The unique method of the Wesselhoeft provings also deserves attention. For the purpose of obtaining health records from his provers, milk sugar was administered to sixteen persons instead of the remedy and in six weeks 919 symptoms were reported by them. It is to be regretted that only five of these provers entered into the subsequent proving of carbo veg. This was certainly an advance step towards more accurate provings because if we grant that Dr. Wesselhoeft was in error in considering saccharum lactis such an inert substance that no symptoms could be produced by it and therefore that those reported belonged to the provers themselves and constituted their health records, yet such records could be obtained by making a proving of milk sugar in connection with that of every

remedy. From such a large number of comparisons the true symptoms of milk sugar would easily be known and then by exclusion, the remaining symptoms would be the prover's health record. Wesselhoeft's reproving was adopted by Hughes and Dake in the *Cyclopædia of Drug Pathogenesy*. Taking this work as a basis the Medical Investigation Club of Baltimore, applied the method of analysis and synthesis to the provings and still further reduced the symptoms to 67. Allen, in his *Primer of Materia Medica*, gives about 152 and Cowperthwaite mentions about 181. It is to be hoped that we may yet have a thoroughly scientific proving of this remedy and that its symptomatology shall be recorded in terms that are in accord with the present state of medical science.

In studying the action of the remedy we may first of all generalize and express its action by the terms deficient oxidation. It is a coincidence that the same words express the chemistry of its production. Dr. Dewey in his admirable summary gives five characteristics of the remedy. 1. Offensive discharges. 2. Putridity and burning. 3. Coldness of legs and knees. 4. Venous sluggishness to stagnation. 5. Flatulence. We may, however, go still further and from the fourth, "venous sluggishness to stagnation," all the others may be derived.

Adynamia is therefore a characteristic, and hence the remedy is indicated in the aged or for those in whom the retrograde metamorphoses overbalance those of nutrition. Careful investigation having shown that all nerve action originates in the production of heat that takes place in the various glands, the nervous system is gradually depressed and exhausted by a remedy, such as carbo veg., that interferes with this oxidation process. Hence we find that the mind is oppressed; there is anxiety; the patient becomes peevish and irritable; is easily excited to anger and violence; pains are frequently described as burning; there is vertigo, and headache is prominent, with acute pain in the side of the head (sometimes in both sides) or in the temporal region of the left side, and less frequent in the occiput.

The following symptoms, referable to the spinal cord and nerves, I have collated from *Therapeutics of Spinal Diseases*, by Dr. De Derky, of Mobile. They are all from the *Materia Medica Pura*: Sensation of warmth in the back and up to the

neck; also of tension, as if in the cervical vertebræ; stiffness in the nape of the neck; sharp stitches in the shoulder-blades, taking the breath away; drawing sensation in the back; arms feel heavy; sensation of weakness in the hands, as if paralyzed; tensile feeling in the small of the back, with stiffness or sensation of cold and numbness; feeling as if a plug were in the small of the back; sharp pain in the lumbar region (this symptom was reported by Wesselhoeft's provers and verified by the Baltimore Club); pressive sore pain beneath the coccyx.

Secondary to its action upon the nervous system is its effect upon the circulation. This is made sluggish, so that cold hands and feet are encountered, and the patient is apt to be worse in damp weather or susceptible to changes of weather. The general relaxation is shown in the head by confusion of ideas, making thinking difficult, and there is a heavy feeling, which even extends to the eyes. The disturbance of circulation is shown most markedly through the mucous membranes, and, in acute catarrh of the upper air passages, it is a useful remedy. There is discharge of mucus from the nose, with sneezing and crawling sensations. In the debilitated there may be epistaxis, severe and repeated. In the mouth there is an irritable condition of the mucous membrane of the lips, with tendency to ulceration. The throat feels sore and irritable, with expectoration of mucus. There may be scraping, rawness and burning in the larynx and trachea. The soreness is apt to increase towards evening. The remedy is also indicated in painless aphonia, and Jousset says that "This loss of voice, without remission, is comparable with that produced by paralysis of the vocal bands, and is a sure indication for the remedy. Talking is not accompanied by pain in the larynx, but cough, when present, occasions burning pain."

The Baltimore Club calls attention to the fact that there is no pathogenetic authority for "hoarseness," it being simply inferred as a concomitant symptom. Passing down the trachea, we find it causing a sensation of weakness and fatigue in the chest, with burning, rawness and soreness. Hence, according to Farrington, it is indicated in the bronchial and pulmonary affections of the aged, or in those easily relaxed by a warm, damp atmosphere; the sputa may be purulent and offensive; there is great difficulty in breathing, and there may be haemoptysis of

dark thin blood. Also in the asthma of old or weak persons, who have a deathly sick look, with disorders of digestion. Such patients are apt to express their need of oxygen by wanting to be fanned. In the mucous membranes of the digestive tract we have the chief action of our remedy. The tongue is furred either white or yellowish-brown; there is a disagreeable taste, and aversion to meat, to fat things and to milk; the appetite is diminished, and there is thirst, with nausea, and sour or bitter eructations; there is a feeling in the stomach as though it contained a foreign body, and a burning pain extending to the back.

According to the genius of the remedy, we find a condition approaching putridity. As Farrington expresses it, the patient has passed the stage which *nux vomica* or *pulsatilla* should benefit; the stomach is suffering from continued debauches; it feels tense and full; even milk causes flatulence; all digestion is at a standstill. As if in sympathy with the stomach, we find a tender, sore and painful abdomen; it feels full to bursting; the colic is worse from the least food, but is better from passing flatus; there may be diarrhoea or constipation; if the former, the stools are enveloped by filamentous yellowish mucus, which becomes bloody in the last portions; there may be much urging, with burning in the anus after stool. Hence, the remedy is useful in dysentery with offensive stools and great prostration.

Constipation and haemorrhoids may occur. The latter are apt to be dark and to burn like fire and to be made worse by any aggravation of the stomach trouble. There may be also a more or less constant oozing of moisture from the anus. The piles show the sluggish portal circulation which also manifests itself in enlarged veins in the lower extremities and a tendency toward low-graded ulceration with formation of offensive pus. These ulcers are apt to be flat and superficial with burning pains that are worse at night. Incontinence of urine at night and frequency of micturition express its action upon the urinary organs. The burning and soreness and prostration of the remedy extend to the female sexual organs and we have menstruation too early and too profuse, with thick blood of a strong odor. There is also acrid leucorrhœa, worse in the morning, and varicose veins of the pudenda.

In the above I have attempted to give a fair outline of the effects of carbo vegetabilis as known up to the present time, and shall close this paper with a consideration of the remedy in collapse. We have seen that the key-note of our remedy is adynamia, and that it is attended by failure of the circulation, by blueness and coldness of the surface of the body, which shows the imperfect oxidation of the blood; that the pulse becomes thread-like, weak and faint and according to Cowperthwaite, even Cheyne-Stokes breathing is given as a symptom. This is a picture of collapse, but it is the collapse of slow disintegration, the result of old age or of slow-wasting processes. Richard Hughes says, "I cannot agree with those who see a carbo adynamia in the collapse of cholera." As a general statement this is evidently correct. The collapse of cholera is usually credited to the effect of a toxalbumin generated in the intestines by the coma bacilli. This is a poison so active as to frequently cause collapse and death within twenty-four hours. It must be a superficial symptomatologist who finds the remedy that we have been considering to be homœopathic to such a condition. The isolated symptoms of collapse under carbo veg. do indeed seem to be similar to those presented in cholera, but this is mere word-matching, as the very genius of the drug is against their similarity. Remedies that are homœopathic to the collapse of cholera must be poisons that are active irritants, quick and overpowering in their effects. Such remedies we have in cuprum, arsenicum, veratrum alb., hydrocyanic acid, camphor, and possibly secale cornutum.

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## THE HEART AT THE BEGINNING AND ENDING OF THE MENSTRUAL LIFE.

BY E. M. HALE, M.D., CHICAGO, ILL.

(Read before the Illinois State Homeopathic Medical Association at Ottawa, Ill.,  
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THE two great and important epochs of a woman's life are the menarche (beginning of the menses) and the menopause (ending of the menses).

Both periods may be attended by functional and structural changes in the heart.

I propose first to treat of those derangements of the heart which occur at the menarche, that period when the child is passing through the changes which end in womanhood.

These cardiac derangements are too often neglected by parents and physicians, who either ignore them or pass them lightly by, as being a necessary part of the girl's life at this period.

A neglect to estimate the symptoms of the menarche at their proper value often entails serious troubles which continue throughout a woman's whole life.

I shall attempt to point out the symptoms which call for medical attention, and the treatment of these by medicinal and hygienic remedies. There are three distinct morbid states, which may be described as follows:

I.—This state sets in before the appearance of the first menses, and disappears some time after their establishment. The heart becomes irritable, there is nervous palpitation, or attacks of paroxysmal tachycardia. The digestion may suffer in sympathy: the appetite decreases; digestion is retarded; there is constipation; nausea frequently occurs, and there is sometimes vomiting of food. The girl loses her cheerful and joyous manner, becomes quiet and introspective, with no desire to learn or exert herself. She easily becomes angry or irritable, sleeps badly, thinks she has some serious heart disease which will ultimately cause her death. These symptoms are all apt to become worse about the first of every month, at the time the menses ought to appear.

*Treatment.*—The treatment should not be directed to the heart alone, although palliatives for its disordered action should be given. Aconite will generally control the palpitation if the pulse is small, hard, and rapid; with anxiety, etc. In some plethoric subjects, with hard, large pulse, veratrum viride will suit better. Cactus is an efficient remedy when the heart feels constricted, with weeping moods, fulness of the head and chest, with epistaxis. In some cases lilium ought to be useful. Ferrum phos. should be of benefit in sthenic cases, with apparent plethora. For the generally deranged condition, pulsatilla, senecio, calc. phos., sepia, graphites and merc. dulcis will be found useful. No emmenagogues should be used, or hot foot- or sitz-baths, nor any forcing measures. Their use often lays the foundation for uterine and ovarian disorders. Vigorous exercise in the open air is the greatest of all remedies, while sedentary habits, with music, novel reading and late hours are very injurious.

II.—The second state is observed in chlorotic girls whose periods are strikingly delayed, even not appearing at the eighteenth year. The external genitals appear well developed, or they may be still undeveloped; the mammae are small, there is but little hair on the pubes. In some instances I have treated, the clitoris was found bound down by adhesions from early vulvitis, or the hood projected too far. In such cases chorea without rheumatism often occurs. Such girls are hysterical, erotic, and sometimes masturbate.

In another class of cases, the first menses may have appeared at fourteen or fifteen years, then become irregular, scanty, or too profuse, often going three months without a flow.

In these two classes of cases the cardiac affection occupies the foreground, so that organic disease is at once thought of. Frequent and violent palpitation is the most prominent symptom, with throbbing of the carotids, dyspnœa and anxiety on continuous movement, or from slight excitement.

On examination the heart is not found enlarged, the sounds are clear, though there are frequently systolic mitral murmurs, or even murmurs at other valves. In the jugulars the brûit de diable is audible. The pulse is accelerated, at times irregular, and easily compressible. The skin of such a patient is very pale, whitish yellow; the visible mucous membranes are very

pallid, the haemoglobin is decidedly reduced, the red globules decreased in number, and there is a constant sense of fatigue and a series of neurotic symptoms. Many have sweating of the palms of the hands and soles of the feet, cold extremities, some oedema, and blueness of the nose and ears.

*Treatment.*—The chief indication in the treatment of the cases above described is to enrich the blood.

Drugs will not alone accomplish this. A life in the open air which is pure, full of oxygen, and free from any form of malaria is more important than anything else, except good, nutritious food containing the blood-making elements. Unfortunately, girls suffering from chlorosis have a repugnance for nearly all the foods they ought to eat.

Almost enforced feeding is often necessary to restore their health. They should eat moderately of beef, mutton, lamb, game, eggs, oysters, bacon, almonds, pecan nuts, hickory nuts. (A nut-meal is now made which can be mixed with soups and other foods.) All fresh vegetables, particularly apples, celery, spinach, dandelions, peaches, figs, wheat-gluten, oatmeal, good bread, but no new bread is allowable.

Iron preparations are of value only as carriers of oxygen to the blood. Those with which I have had the best success are the carbonate, phosphate, and the peptonized iron and manganese (Gudès). I value highly the arseniate of iron, alternated with ignatia or pulsatilla when indicated. In severe cases of chlorosis with failing heart and great mental depression, oedema of legs, dyspncea, palpitation on exertion, thirst for cold water, and craving for ice, arsenicum alone will work wonders. In several cases I have found the arseniate of gold ("arsen.-auro.") a very efficient blood maker, and a tonic to the nervous system.

The condition of the bowels in chlorosis should be carefully watched. If constipation is present, the blood may become poisoned by toxic ptomaines, which aggravate the anaemia. If nux vomica, strychnia, mercurus dulcis, or sulphur does not regulate them we should not hesitate to prescribe the pill "aloës, belladonna, strychnia and ipecac," one or two every night. A daily evacuation every morning is essential to a cure of most cases of chlorosis.

The perturbed action of the heart can be palliated by cactus, convallaria, strophanthus or digitalis. If it is persistently weak

and irregular in action, digitalis combined or alternated with iron and strychnia should be given until its rhythm and the normal pulse rate is restored.

In mild cases, characterized by irregular menses, leucorrhœa, nervousness, and not much anaemia, senecin 1x and scutellaria 1x, each three times a day, will act favorably.

If the case is really one of delayed puberty, owing to slow development of the generative organs, with ovarian torpor, such medicines as phosphorus, damiana, aurum, sabal and conium can be used to advantage.

III.—A third form of cardiac disease which may develop during the menarche is hypertrophy, and is dependent on the changes in the circulation. It is also favored by the rapid growth which is quite common in girls just before the menses appear.

These patients may be neither anaemic nor nervous, but are often strikingly slim and lank, and have "suddenly shot up" during the past year. They complain of violent palpitation, a feeling of fulness in the chest, and dyspnoea on rapid movement, or climbing stairs and hills. On examination, the heart will be found to be enlarged, especially in length. It is a real thickening of the heart muscle, keeping pace with the growth of others in the body and limbs. The radial pulse is abnormally strong and resistant, the heart-sounds are augmented and the apex-beat heaving and distinct. These patients are not usually from the working-classes, so that it is not due to over-work, but to the extra demands made upon the heart by rapid growth and the sexual development, both pelvic and mammary. It is the same kind of hypertrophy which occurs during pregnancy, and, like it, generally disappears in a few months or a year after the menses are fully established. A similar hypertrophy often occurs at the change of life, when the menses cease to recur, and the blood, which has been habitually lost, floods the circulation and augments the work of the heart.

*Treatment.*—In the treatment of the cardiac hypertrophy I have just described, medicines are of but slight value, except as palliatives. There are no drugs homœopathic to plethora and super-normal muscular development. Iron is the nearest simillimum, but minute doses of iron cannot remove the condition. We must rely upon hygienic measures. We must cut

off the supply of blood-making foods. We must prohibit beef and other red meats and eggs, and allow only fish and a little white meats. We should not permit athletic exercises, which tend to increase muscular development of the heart. At the same time a life in the open air should be advised.

The most efficient of all the palliatives for this hypertrophy of the heart is *veratrum viride*. When we find the pulse large, hard and bounding, the heart's impulse forcible, and the general arterial tension great, this drug is indispensable. Beginning with five drops of the 1x, the dose can be increased if necessary to five drops of the tincture, repeated every four or six hours. Under its use the pulse softens, slows, and the dyspnoea and violent beating of the heart become normal.

If this does not occur in a few days, and the high arterial pressure persists, some portal obstruction must exist. In such cases a few grains of *mercurius dulcis* 1x, sufficient to unload the bowels, will remove the obstruction and allow *veratrum viride* to exert its physiological action.

In a few cases I have seen good effects from *glonoina*, *bella-donna*, *aurum*, *gelsemium* and *aconite*.

If the kidneys are sluggish, a few grains of citrate or tartrate of potash, *apis* or *cantharides*, given three times a day, will relieve the renal congestion.

*The Heart at the Menopause.*—The physical conditions which affect the heart at the change of life differ considerably from those which obtain at the beginning of menstrual life.

*Chlorosis* seldom, if ever, appears, and true *anæmia* occurs but rarely. If we find any *anæmia*, it is from loss of blood, due to the *hæmorrhages* which at the menopause are often profuse.

The disturbances of the heart from loss of blood are often very distressing. We find excessive palpitation on exercise, climbing stairs or from sudden emotions; rapid beating of the heart, except when lying down; distressing, hammering sensation in the head, and difficulty of lying on the left side.

These disturbances from loss of blood may closely imitate *valvular disease*, for we may find a murmur at the valves. The kidneys may become torpid, owing to insufficient blood pressure, resulting in *œdema* of the extremities and often of the whole body.

*Treatment.*—The treatment of this form of anaemia consists of physical and mental rest. Riding in an easy carriage is of benefit if not too long continued. The benefits of open air can be obtained by opening the windows, even in winter, if the patient is well protected. We do not treat the heart directly to the exclusion of the whole body. The blood must be restored to its normal quantity. Blood-making food should be advised; all the easily digestible meats, fresh vegetables, fruits and the cereal foods, containing their normal quantity of albumin and gluten.

Generally, cinchona is the most appropriate medicine; but I have learned not to rely on minute doses. Ten to twenty drops of the 1x or tincture of cinchona rubra every four hours will hasten the restoration of the blood in a very short time.

Iron is rarely indicated; and I have observed that it seldom agrees with such patients. Enough iron can be assimilated from apples, spinach and the cereals. If any form of ferrum is prescribed I would advise the acetate in small doses, or haemoglobin (a tablet after meals). Aletris, hydrastis and nux vomica are very useful. If the heart becomes very weak, and there is danger of dilation of its cavities, we are obliged to resort to digitalis and strychnia alternately, five drops of the former and  $\frac{1}{100}$ th grain of the latter, each three times daily.

Plethora is the usual abnormal condition at the change of life, especially when the menses cease abruptly. The arterial and venous systems become engorged, and unless some of the sources of blood supply are cut off or some outlet is established, all the internal organs, even the heart itself, may suffer severely. Violent and distressing palpitation is common, and epistaxis, haemoptysis and other than uterine haemorrhages often appear.

*Treatment.*—The diet should consist almost entirely of vegetable food, although fish and some of the delicate white meats are allowed. No alcoholic or malt liquors are permissible, although the craving for them is often great. Dr. Tilt remarks that such patients often complain of utter prostration and beg for stimulants; but he cautions against their use, for they always aggravate the sensation of depression. The bowels should be kept loose by the use of mineral waters containing sulphate of soda or some mild laxative salt, but no iron.

Arterial sedatives, aconite, veratrum viride, gelsemium and

sometimes cactus will give great relief in such cases. I have often kept patients with engorged arteries under the influence of veratrum viride for weeks with none but the best results. A few drops of the 1x three times a day are often sufficient.

There is a variety of palpitation of the heart which frequently occurs at the change of life, which is a purely nervous affection bordering on hysteria. Usually, but not always, it is excited by emotional causes; but it may be excited by an irritation of the sympathetic nerve, emanating from the abdominal nerves. This variety of palpitation is often attended by or alternates with aortic pulsation, a very curious symptom and often difficult to cure. The medicines appropriate to these symptoms are, first of all asafœtida, and then castoreum, sumbul, scutellarin, cypripedium, symplocorus, ambergris, valerian, moschus, camphor, coffeea and cannabis indica.

For special symptoms indicating these medicines, consult our *materia medica*. They are all indicated in cardiac and visceral neuroses. Some old-school text-books like Stillé's *Materia Medica*, unwittingly give excellent indications which are mostly homœopathic, also their special sphere of action. You can hardly treat the hysterico-cardiac neuroses of the menopause, without asafœtida, but you must not confine yourself to any one dilution. Often the 3x will give good results, but oftener the one-grain pill will be more satisfactory.

There are some symptoms of the menopause that are often mistaken for cardiac disorder. I allude to the "flushings" which are so annoying and distressing. You are all familiar with them, and are doubtless often asked by the sufferers to explain their nature. These "flushings" represent in miniature the phenomena of a paroxysm of ague, namely, a chill is followed by intense heat spreading all over the body and ending in a copious perspiration. These three stages often occupy not more than a minute or two. Often only two or one of the stages are present. During the chill the heart's action is feeble, but during the heat there is violent palpitation with headache, vertigo and turgescence of the face. The cause of this phenomena is an irritation of the vaso-motor centres, during which the arteries are first contracted, and second, a paralytic stage, in which the arteries are relaxed. The heart disturbance is a consequence of the relaxed arteries, just as when the arterial

coats are relaxed by nitro-glycerine—the heart bounds and throbs in its efforts to fill the paralyzed blood-vessels. I have known the first or chilly stage cause symptoms resembling angina, probably due to a narrowing of the coronary arteries. In some rare cases I have known nitro-glycerine cause all three stages of "flushing." This makes it a very homœopathic remedy for these symptoms.

*Treatment.*—Where nitro-glycerine is indicated it should not be prescribed lower than the 8x, and repeated several times a day as a preventive, or every fifteen minutes during the paroxysm. Amyl nitrite is often of service, as its action closely imitates glonoine and should be given in the same doses.

Pilocarpin is often of value in the 8x attenuation. Atropin 6x is indicated when there is no chill or sweating.

Lachesis, first recommended by Hering, is a remedy of great value, as I have verified in many hundred cases. Probably all the serpent poisons may be indicated. Sepia, sanguinaria and pulsatilla have been used successfully.

There is a condition of the coats of the arteries, designated as atheroma, which causes a great many symptoms often mistaken for cardiac disease.

Atheroma is a fatty degeneration of the coats of the arteries, which leads, sooner or later, to a stiffness and brittleness of the arterial walls, due not only to the fatty degeneration but a deposit of caleareous nodules and plates. This last condition was once called ossification. This degeneration, unless caused by syphilis or arteritis, is a senile change, and does not commence under the age of forty or fifty. But unfortunately its beginning coincides with that critical period in a woman's life.

The symptoms caused by atheroma, especially when the peripheral blood-vessels are affected, are those of defective cerebral circulation, giddiness, fainting fits, irritability of temper and defective mental processes. If the coronary arteries or the root of the aorta are affected, the symptoms are those of attacks of angina pectoris. Atheroma may even cause organic changes, secondarily—such as hypertrophy, dilatation, mitral incompetence, with the usual symptoms attending these conditions. The serious and fatal results of this condition are apoplexy from rupture of a cerebral vessel, embolic plugging of a cerebral artery, or cardiac syncope.

If a woman at the menopause complains of cardiac distress or pain, we should always examine the radial and temporal arteries for rigidity.

*Treatment.*—When we find an atheromatous condition of the arteries in a woman at the change of life, we should first remove the causes of that condition. Alcohol is now considered a prominent cause, and all alcoholic and malt liquors should be prohibited. Fatty food is not believed to cause any form of fatty degeneration, but the excessive use of sugar may. If the patient has been the subject of syphilis, the iodides, particularly iodide of soda or baryta, are undoubtedly useful; but it is not necessary that syphilis should be a cause in order to make the iodides valuable. Iodine 3x or iodoform 6x may be of benefit. The latter drug has caused fatty degeneration, and is therefore homœopathic. Iodide of iron is of decided value if the patient is anaemic. In order to have permanent benefit from the iodides, they should be continued for months.

The diet of such patients should be simple and nutritious. It is suggested that the drinking water used should be as free from lime as possible. Beef and mutton are said to be injurious, as leading to undue plethora.

All the nitrites are of great value, not only as palliatives, but to keep up a continuous relaxation of the arterial coats. I have given glonoine (nitro-glycerine) in bad cases, continuously, for months, with great benefit. Generally the  $\frac{1}{100}$  grain three or four times daily will suffice, but some patients have taken with benefit  $\frac{1}{20}$  grain, without any disagreeable effects. The more rigid the artery, the larger the dose of a nitrite is required.

In the anginose attacks, prompt relief is given by the inhalation of a few drops of amyl nitrite. Cactus seems to me the best and safest of all the cardiac remedies in atheroma. Dr. Snader, of Philadelphia, in a recent paper on the clinical uses of cactus, asserts that a weak heart with atheroma is the special field for the beneficial effects of this drug. I have, however, given digitalis, strophanthus and spartein, alternated with glonoine to prevent arterial tension, with good results in cardiac dilatation from atheromatous arteries.

All structural changes in the heart are necessarily aggravated at the change of life, and their treatment must be conducted on general principles, as at any other age.

## ULCERATION OF THE AORTA FOLLOWING NECROSIS OF VERTEBRA.

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THE following case was admitted to the Hahnemann Hospital of Philadelphia on December 12, 1895, under the care of Dr. C. B. Knerr, to whose kindness I am indebted for the following records of the case:

F. B. C., male, 46 years of age, unmarried, American, painter by trade; family history negative. With exception of small-pox, at sixteen years of age, always enjoyed good health.

The history of the present illness is as follows: Something over one year ago, while working at his trade, he fell from the third story of a building, striking upon a fence, fracturing three ribs of the left side. Since the accident, he has never been well. Three or four days before admission to the hospital he started to work for the first time since his fall, but suffered so much from pain in the left side and in the abdomen that he was compelled to stop work and go to bed.

Upon admission to the hospital, he complained of severe cramp-like pains in left side of abdomen, commencing at twelfth rib and extending to pelvis. When turning upon right side, the pains would shoot across abdomen, accompanied with feeling of weight. For several weeks his bowels have been constipated, gradually growing worse, and, at time of entering hospital, they were moved only by means of a purgative.

Physical examination showed deformity of ninth, tenth and eleventh ribs of left side; tenderness in dorsal region of both sides, most marked on left side; a distinct mass extending from margin of ribs to pelvis on left side and from median line to side, completely filling the left abdominal cavity. This mass was firm and immovable, percussion note flat, and the mass was painful to firm pressure.

Upon admission, his pulse was 82; temperature, 98.5° F.; respirations, 15.

Examination of urine, January 1, 1896, showed sp. gr. 1022; acid reaction; free from albumin and sugar. No other

examination of the urine was made. A synopsis of his condition while in the hospital is as follows:

On December 31, 1895, the night of his admission to the hospital, he was very restless all night on account of pain in back, side and abdomen; unable to lie upon either side; no appetite; bowels constipated.

January 7, 1896.—He complained of scalding sensation in left lumbar region, and severe pains in back.

January 11th.—Feeling much better and sat up in chair. Still no appetite and bowels constipated.

January 14th.—Return of scalding sensation in left side.

January 19th.—No pain, but left side sore.

January 22d.—Unable to sleep on account of severe pain in back and left side.

January 25th.—Pain in left side, accompanied by numbness in limb.

January 28th.—About same, except complained of tenderness in abdomen. Scalding sensation in back and down left side. Bowels constipated.

February 1st.—Refused all food. Pain in back, and side severe.

February 2d.—Slept very little during the night, complained of feeling weak and chilly. During the twenty-four hours had four loose bowel movements.

February 3d.—Feeling weaker between 8.45 A.M. and 11.10 A.M.; had four dark, watery bowel movements.

At 11.15 A.M.—Patient, against orders, got out of bed unassisted, to use commode; suddenly became weak and faint; pulse rapid and small, shortness of breath, and at 11.35 A.M. expired.

*Necropsy.*—Thirty hours after death. Body emaciated. Rigor mortis well marked. Upon exposing the contents of the abdomen, the intestines were found to be crowded to the right side, the left side being completely filled with a dark, firm, subperitoneal mass, to which one or two coils of intestines were adhered.

Continuing the examination, the lungs were congested in lower lobes, the upper lobes anaemic, right pleura free, left pleura adhered at site of old fractures of 9th, 10th and 11th ribs.

Heart small and empty, as were the large arteries of the body generally. The other organs, with the exception of the left kidney, were normal but decidedly anæmic.

Removing the abdominal contents, the mass in left side was completely exposed to view; it was firm, dark, and in direct contact with the abdominal walls in front. The left kidney was found compressed, anæmic, and fatty. Upon cutting into the mass it was found to consist of an organized blood clot, about one and one-half inches in thickness, with a fresh clot beneath, which was easily removed by the hand.

The aorta being cut longitudinally, the ulcer shown in the photograph was disclosed. This was three-quarters of an inch in diameter, round, with rounded edges, the edges being entirely covered with endothelium. The base was necrosed bone, which upon dissection of the aorta was found to be the body of the 12th dorsal vertebra. The cartilage between the 12th dorsal and 1st lumbar vertebrae was displaced three-eighths of an inch forward, causing a prominence of the spinal column at this point.

The edges of the ulcer were firmly adhered at point shown by the white line in photograph. At the lower border the adhesions were broken as shown in photograph, where the last, and probably the first, haemorrhage took place.

After the first haemorrhage the pressure of the subperitoneal blood was equal to pressure in the aorta and the escape of blood ceased, the opening being temporarily closed. But with the organization of the clot, and the contraction following, the exertion of the patient in getting out of bed again caused a second opening and fatal haemorrhage.

When did the first haemorrhage take place? Certainly before admission to the hospital, as the tumor was diagnosed upon first examination. Were the scalding sensations he complained of caused by frequent haemorrhages? His symptoms would indicate this; also the consistency of the under clot, which though soft, was in several layers of varying stages of coagulation. That the ulcer was of long standing is shown by rounded edges, which were shown perfectly covered with endothelium. That the accident is responsible for this is shown by the displacement of the two vertebrae mentioned, the twelfth dorsal becoming uncovered and pressing upon the soft tissues in front,



FIGURE I.—Internal View.



FIGURE II.—External View.

caused a sloughing of these parts, and the perforation of the aorta followed. The case is interesting in that so large an area in the main artery of the body could slough, and none of the slough be carried to distant parts, causing emboli. Again, the blood, with every heart beat, was forced over this ulcer, whose base was ulcerated bone, and no coagulæ with distant emboli were formed. In no part of the body were signs of old or recent emboli or thrombi discovered.

I am indebted to Dr. Nichols, of the resident staff, for the photographs, which he kindly made for me.

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## WHAT IS THE ACTUAL SIZE OF HOMŒOPATHIC MATERIA MEDICA?

BY M. W. VAN DENBURG, A.M., M.D., FORT EDWARD, N. Y.

ONE of the necessary things to an intelligent comprehension of the needs of homœopathic *materia medica*, is an adequate idea of its extent on the one hand and of the possibility of omission and condensation without injury on the other.

Many wrong ideas are held by those who are anxious for a complete, concise and usable *materia medica*. This is not only the case among those who are accustomed to take all their medical ideas second-hand, but also among those who have given the subject much anxious thought.

If it so happened that the most *useful*, the most *characteristic* and the most *indispensable* symptoms of a drug, were the ones most frequently met in provings and toxic cases, and if the uncommon and unique symptoms were always of little value, then a general rule based upon these principles would not be difficult to formulate, and its application would be easy in reducing the enormous size attained by the *materia medica* at the present day.

Any one who has looked up the origin of the most important symptoms of our useful drugs, the symptoms on which most reliance is generally placed in differentiating it from allied drugs, has met with many surprises in regard to the frequency or the infrequency with which these important symptoms have been manifested.

I will not here attempt to give a reason for this, further than to say, that symptoms which seem to be side lights to a proving, and only manifested in peculiarly sensitive persons, have often proven the most constant and useful guides in prescribing. Such is the drinking little and often of arsenic, the furious delirium of belladonna, also the sleepy but can't go to sleep of the same remedy.

This list might be indefinitely extended to include almost every polycrest and to prove that the symptoms, seeming at first view to be of inferior value, are often, when brought to the test of actual experience, found to be most valuable.

It is the fear of omitting just such symptoms as these that constantly menaces the author who sets himself the task of *condensing* homœopathic *materia medica*. That this fear is based upon a genuine danger is proven by all the results of condensation that have thus far been attempted. Some of the brightest and most philosophic minds in the profession have attacked the problem from this side, and not a single solution thus far has been a *working* success. The theories they have propounded have been most excellent; but practically a lamentable waste of time and energy.

After testing the results for a time, the follower and leader have alike found they were inadequate for the application of the law of similars. They do not meet the bedside requirements in the application of homœopathic methods of prescribing; and I will venture the opinion that most of those who have tried to use them, have either drifted into "going on general principles," or into "routine prescribing," or "physiological views of the action of the drug," or into a complete abandonment of their generalized condensations for practical purposes.

The reason for these results is at hand. In a word, it is individualization. This idea and method of individualizing cases was so new and so utterly foreign to the medical thought of Hahnemann's time, that it was a discovery second only to the method of selecting drugs by similars.

All schools are to-day learning the value of this method. The brightest and foremost men in the allopathic school are crying from the housetops that you ought to treat your patient and not the disease name. The great practical value of this truth cannot be overestimated, and homœopathy started with

this as the second foundation-stone, the first course above the method of similars.

Individualization of the patient is but the other half of individualization of the drug. Or, if you wish to turn it about, individualization of the drug is just as indispensable as individualization of the case. Perhaps it might be put even stronger; without individualizing the drug, individualization of the case is useless. Of what benefit is it to study your case never so carefully, if you do not use equal care in the measures taken for his restoration. Hygiene, mechanical accessories and mental and moral influences need to be assisted by the selection of the suitable drug-influence, if one would make the highest success of the healing art.

In the selection of the suitable drug, no method is superior to that which strives first to know the *whole sphere* of action peculiar to the individual drug. It is not the most "general action," it is not the plain "physiological effects," it is not the "remote effects;" but it is the entire individual unity of the drug-effects, the *unique, particular and special character of the drug-unity* as distinguished from all other drug-unities that is sought. When this is found, comprehended and properly applied, the results are magical. Such a use of drugs brings its own reward.

Such an application of drugs lies, for the present, pre-eminently in homeopathic teaching. To preserve homeopathic ascendancy in this direction, there must be not less, but more careful, individualization of drugs. This is the "open sesame" of our future medical success.

And allow me to repeat, the individualization of the drug is the *alter ego* of individualization of the case.

Now we are prepared to consider what individualization of the drug requires.

In the first place it requires a large number of provings; that is, a large number of provers.

Why a large number?

Because there are two elements in every drug-proving; the individuality of the drug and the individuality of the prover. If the drug is pure and properly prepared, that side of the problem remains a constant quantity; but the individuality of each prover remains unique. We gather as many of these

unique assemblages of symptoms as we are able. We bring them together and compare them.

"Scientific Medicine" would say, from these comparisons we generalize, as in all other scientific deductions, and we arrive at the "general character and effects of the drug." This looks plausible, but it is a very specious deception. This is what we have already condemned as the bane of medical practice. We do not strive to cure man in general, but a particular man, with his particular combination of qualities, and he requires particular treatment, and the above generalizations are not only misleading, but they are useless; they conduct us by the wrong route.

Similar causes produce similar effects, and the reason why the same disease produces such diverse effects, is because of diverse individual qualities in patients. So too with the drug. It is this peculiar personal effect of the drug that needs to be matched with the peculiar effect of the disease. Is it not likely, is it not certain, when a drug acts in a peculiar manner on a certain prover, it is because of his peculiar constitution, and when a sickness manifests a similar peculiar symptom, it is because *the patient is peculiarly like the prover in his individuality?*

If this be true, and it seems to me it has a large amount of experience to back it, then we cannot throw out peculiar, unique and incongruous provings without at once lessening the value of homœopathic *materia medica*.

I beg a most attentive consideration of this question, for on it hinges a most important deduction.

If homœopathic *materia medica* is to be condensed, if a certain class or classes of symptoms are to be rejected, it is quite certain that *it cannot be the unique*.

Can it be "the general symptoms, such as are common to all drugs?"

This is hardly possible. The general symptoms are like the bones in the anatomy of the body. They are the fundamental skeleton upon which the whole drug-sickness is built.

Omit them, and all the rest falls into a shapeless, unorganized, helpless aggregation of facts, without an adequate theory for their explanation and unification.

If then, neither the unique nor the very common symptoms

can be eliminated without loss too great to be overlooked, what other class remains to be omitted?

I imagine a chorus of well-known voices calling out, "Omit the unreliable symptoms."

What is an unreliable symptom? Is it one that proves false on repeated trial? One from which we appear to elicit no favorable response, when the drug is applied with special reference to that symptom?

If that be the case, how can we know it is unreliable until it has been tested? And how can it be tested until it is known? And how can it be known except by giving it a place in the *materia medica*?

Let no one suppose for a moment that the writer believes all symptoms now recorded are true symptoms, or that all have a practical value. This is exactly the opposite of what he does believe. But as yet no way has been found to sift out the chaff without throwing away much good wheat. Or to use another figure, the gravel seems not very rich, but if thrown away by the shovelful without examination, many of the most valuable nuggets will go into the dumping heap, and the man who works over the refuse will get the most gold.

What, then, is the size of homœopathic *materia medica*?

Any comprehensive work that shall include all the symptoms, and mention a given symptom only once, or at least just as few times as is possible in an index (and on account of the nature of an index a symptom must occasionally be repeated), and that shall arrange all these symptoms so that they may be readily and easily consulted, must reach to not less than ten or twelve volumes of six to seven hundred pages each, if not more. Certainly it cannot be any less. It is of no use to disguise the fact, that such is the case with the *condensed form alone*.

Now if one would know the relation any given symptom sustains to other symptoms in the same pathogenesis, he must have a still more extended work. Twenty-five volumes at least must be made.

But says some one, What is the use of all this? It can never be of any avail. It will be wholly impracticable; no man can use it.

For one I do not think this is the case. I am inclined to

take the view that exactly the opposite is true. You want to know more and not less about the possibilities of sulphur, bryonia, gelsemium, rhus tox., and hepar sulph.

All the methods by which you propose to lessen the bulk of homeopathic *materia medica* look to limiting and not extending your knowledge of these and all other remedies.

There is but one way possible in so far as I can see, and that is to throw out a large number of the less fully proven drugs altogether.

But would not this be suicidal to all advancement?

Do we really want to stop proving more drugs?

Who shall decide whether a partially proven drug is useful or useless?

Do you wish to delegate this consideration to any author you can name?

Is that the policy for us to pursue in the future?

I leave my readers to answer these questions for themselves.

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#### VALEDICTORY

TO THE GRADUATING CLASS OF HAHNEMANN COLLEGE,  
PHILADELPHIA, MAY 5, 1896.

BY PEMBERTON DUDLEY, M.D.,  
Professor of Institutes of Medicine and Hygiene, Hahnemann Medical College,  
Philadelphia.

*Gentlemen of the Graduating Class:* The close of a medical student's college life and the beginning of his professional career constitute an event having important related interests. It is of interest to himself, of course, as bearing upon his character, his reputation, his usefulness, or, as men call it, "his success in life." But it concerns others as well. It touches his Alma Mater—the college that will be honored in his success or dishonored by his mistakes and his misdeeds. It affects the medical profession of which he is to form a part, in which he may prove to be either a help or a hindrance, an honor or a disgrace. But more than all else, it is of vital consequence to

the public—to those who, under stress, will commit to his care their highest and best earthly interests—life, health, and the safety of those they love. To-night, gentlemen, all these interests are represented here.

Naturally the uppermost thought in the mind of the student upon the occasion of his graduation is that of self-gratulation upon the completion of a task which has engrossed his time and stimulated his best efforts for a series of years. His rejoicing is as commendable as it is natural. And so, this hour, this occasion, gentlemen, is yours. Enjoy it to the full.

As the relation between us as teachers and students has reached its close, let us revert to two or three subjects which naturally suggest themselves. And first, has it ever occurred to you that there is profound significance in the fact that medical men as such—even the faculty of a medical college—are not permitted to confer the medical degree. That power and prerogative the people, through their constituted authorities, have reserved to themselves, and most wisely too. The State has determined by law that this degree shall represent a specified minimum amount and quality of educational attainment and qualification, and that it shall be conferred only by persons vested with her sovereign authority. The degree thus becomes a public declaration issued by, and on behalf of, the Commonwealth, setting forth that the person on whom it is conferred is qualified to practice the arts of medicine and surgery among the people. Now the significance of this public act is this: That the people have thus imposed on the physician the responsibility of making and keeping himself qualified, mentally, morally, and physically, for the practice of his profession among them, to the end that their interests do not suffer at his hands. The relation thus established between profession and people is wise and equitable to both parties concerned in it. The physician who fails to be constantly influenced by this relationship is not filling up the measure of his professional duty.

But, gentlemen, there is one rather curious feature of this State endorsement of the physician's qualifications: namely, that the State, after publicly announcing to her people that you are qualified to practice medicine and surgery, and that they may safely trust their health-interests in your professional keeping, declines to accept her own statement. To-night she

certifies to your fitness. To-morrow she will examine you to ascertain if you are fit. And, as if to make her self-stultification as complete and glaring as possible, she will refuse to examine you unless you are able to exhibit her certificate. We have no good reasons to give you for this curious action of the State; neither has she. I recommend that you submit to this supernumerary examination with as much grace as you can command, and as much respect as you can possibly feel for an authority which questions its own veracity or competency. Meanwhile you may take pride in the knowledge that the people most nearly interested—those who will be the objects of your professional ministrations—will repose far more confidence in your possession of the diploma of the Hahnemann Medical College than in the license of any State Medical Examining Board this side of the Atlantic Ocean—or the other side either.

Heretofore your views of the subject of medical education have been from the standpoint of the learner. Henceforth you will observe it from that of the practitioner, some of you, perhaps, that of the teacher; and you will not be surprised should your opinions thereon undergo some changes. It is, for many reasons, desirable that the profession should entertain broad and correct views on a subject so nearly related to its honor and progress.

We often hear expressions of regret that American medical colleges do not adopt the general policy and methods of the medical institutions of Europe; but it is noteworthy that we rarely hear such regrets expressed by those who have had much experience in medical teaching. The sentiment in favor of European methods is due chiefly to a failure to recognize the difference in social life and especially of general education, on the two continents, and the equally inexorable fact that the work of all technical schools in the United States is forced to adapt itself to its environing conditions, precisely as it is in Europe. How these conditions affect the education of American physicians can be easily understood.

We often congratulate ourselves upon the relatively small amount of actual illiteracy in the United States; *i.e.*, small, considering the modes and conditions under which our national development is being accomplished. We are constantly draining the illiteracy of Europe, increasing ours and diminishing

hers. Yet we are forced to acknowledge that an unduly small proportion of our youth are able to secure the advantages of an education above the grades furnished by the common schools. Only an almost insignificant percentage of them attain the honor of a degree in arts, science, or philosophy. Yet we hear it urged, with much energy, that none but the holders of the Baccalaureate should be admitted to our medical colleges as students. Let us consider what the results would be, were all our medical colleges to adopt such a restriction.

The practitioners of medicine in the United States now number considerably over one hundred thousand. The average duration of a physician's professional career, from his graduation till his death, is supposed to be about twenty-seven years. It follows, therefore, that the vacancies in the professional ranks, created by death alone, must amount to at least four thousand annually. The last published Report of the United States Commissioner of Education tells us that there were graduated from all the medical colleges of the Union in 1893, a total of 4911 physicians. Considering the annual increase of population to be provided for; considering the number of medical graduates who immediately take up the study and practice of pharmacy, dentistry, or veterinary surgery; considering the number who locate outside of the United States, and the number who give themselves to medical missionary work on foreign fields, and considering the number who drift into lines of general business, it must be asserted that there are few, if any, more graduates turned out by our medical schools than are required for the needs of our population. It is often complained that there are more physicians in the United States, in proportion to population, than in any of the countries of Europe. So there ought to be. The greater sparsity of our population requires it. The charge of overcrowding, so often brought against the medical profession, is preferred with equal energy against other professions and trades, almost without exception.

The Report of the Commissioner of Education just cited gives another important item of information relating to this subject; namely, that in all the literary colleges and universities of the United States in 1893 those who received the degree of Bachelor of Arts numbered 4061; and those who received that

of Bachelor of Science numbered 1153; making a total of 5214. It seems, therefore, that if all those who receive the degree in arts or in science should enter the medical profession, while all others were excluded, it would be but little more than sufficient to supply the medical needs of our population. Such a condition of affairs, however, is not attainable. Not more than one in eight or ten of those who graduate in our literary colleges enters the profession of medicine; while those holding these college degrees do not constitute more than 8 or 10 per cent. of our American medical graduates, and the actual figure is more likely to be 5 or 6 per cent. Even in the medical schools connected with our most renowned universities it is never above 12 or 15 per cent. It is sufficiently evident, then, that the ranks of the medical profession cannot possibly be recruited from among the graduates of our classical and scientific colleges exclusively. Any attempt in that direction would render a course of medical study impossible to a large majority of those who now enter upon it. It would rapidly decimate the profession and speedily degrade it to the level of a cold-blooded, mercenary trade, battening upon the necessities of the sick and helpless, and denying its help to whole communities of people. No; the scheme may be very beautiful as an ideal, but it is Utopian and altogether impracticable.

While the degree of Bachelor of Arts probably represents the best course of preparatory education for the bar or the pulpit, it does not follow as a matter of course that it represents the best course for the practitioner of medicine. We all know that it is no longer regarded as the *sine qua non* of a liberal education. Mr. Harris, the Commissioner of Education, calls attention to the significant fact that for a number of years the percentage of those seeking the degree in arts in our colleges and universities has been steadily diminishing, while the percentage of those aspiring to the degree in science has as regularly increased.

These remarks must not be understood as made in disparagement of a high degree of literary culture for practitioners of medicine. Every one knows that such scholarship is eminently advantageous, and, in some communities and relations, almost essential, both to the physician's standing and to his usefulness. The point we desire to emphasize is, that the stu-

dent and practitioner of medicine are almost exclusively concerned with matters of natural science, and especially with the more practical parts of it; that their technical education rests, or ought to rest, upon a preliminary training in the outlines of nearly all these sciences and upon the development and cultivation of the student's mental powers by exercise along lines of scientific, rather than literary, thought and investigation. In preparation for a medical college course, a good deal more of scientific training, even though it should involve a little less of literary culture (which, by the way, it need not do), would yield better net results by far than the preparatory education now in vogue. With these views of the subject, it appears that the so-called preparatory medical courses provided by some of our most popular universities are susceptible of radical improvement. These educational difficulties and deficiencies may, and doubtless will, be corrected in time; but what shall be done meanwhile?

From time immemorial our American medical schools have felt themselves seriously handicapped by the defective preliminary education of their students. These defects have been painfully apparent in both their literary and scientific training. It is significant, however, that the colleges have unconsciously recognized the latter defect as of superior importance, and have provided special scientific courses as a means of partially remedying it. Thus physics, general chemistry, botany and zoology have come, from long familiarity, to be regarded as parts of the medical curriculum, whereas they are altogether preparatory in character. Why, then, should not the medical schools—why should not Hahnemann College—go still farther in this direction, and establish preparatory courses *in all the other branches* in which the medical student's school-training has left him deficient? Such provision must eventually be made unless general education in this country should exhibit some remarkable changes. We must recognize the fact that the demand for what is called a “classical preliminary training” for students of medicine cannot be enforced in the present state of general education without serious disaster of a public nature, and that some other method should be devised to meet the evident requirements of a competent medical training. Whatever influence you may be able to exert, gentlemen, let it be

directed in behalf of practical, rather than mere ideal, improvements.

Gentlemen: You have the honor of receiving your medical degree at a time when, throughout the civilized world, men are celebrating the Centennial of Homœopathy. One hundred years ago, after six years of profound research, of careful collation and analysis of a multitude of recorded facts, and of tireless experimentation in the field of drug action, Hahnemann promulgated his first conceptions of the new doctrine which was destined to revolutionize the whole practice of curative therapeutics, and open up new possibilities in the domain of medicine. At that time, in 1796, Hahnemann published in *Hufeland's Journal*, at Leipsic, his immortal "Essay on a New Principle for Ascertaining the Curative Properties of Drugs," and this date is universally accepted as the birth-time of the new doctrine. In this essay, Hahnemann sums up the results of his long series of investigations in the following sentences. He says: "Every powerful medicinal substance produces in the human body a kind of peculiar disease; the more powerful the drug, the more peculiar, marked and violent the disease. We should imitate nature, which sometimes cures a chronic disease by superadding another, and employ in the (especially chronic) disease we wish to cure that medicine which is able to produce another very similar artificial disease, and the former will be cured, *similia similibus.*" The entire essay occupies nearly fifty pages of the journal, and its author cites authority to support every statement and corroborate every opinion. A prominent writer, in describing the essay, says: "It displays to full advantage the exceeding gentleness of Hahnemann's temper, the respect he entertained for the opinions of his professional brethren, the modesty of the estimation in which he held his own, and the philosophical and comprehensive grasp of his mind. Its tone was calm and impartial, its assertions moderate, its language clear and accurate, its arguments forcible, its reasoning convincing. It bears no sign of prejudice, much less of acrimony."

Such was homœopathy in 1796. Fourteen years later Hahnemann published his "Organon of the Art of Healing," containing a full exposition of the new science as he comprehended it at that time. His conception of its divine authorship is

beautifully expressed in Gellert's poetic motto, with which he graced its title-page :

"The truth we mortals need,  
Us blest to make and keep,  
The All-wise slightly covered o'er,  
But did not bury deep."

What homœopathy encountered, what it endured, during its first century, we need not pause to consider. Whether it is destined to perpetuate its doctrines and practice, or to disappear, like the numerous allopathic systems that preceded, and like some that have followed it, in either event there will come a time when medical men, freed from the thrall of prejudice and the passion of partisanship, will read the medical annals of the nineteenth century, as they relate to homœopathy, with amazement; and, out of their love for whatsoever things are true and honest, whatsoever things are just and pure, whatsoever things are lovely and of good report, and out of their detestation for whatsoever is the opposite of these, will exclaim in bitterness : "Would God that history could forget."

Because of the coming and the going of the evanescent fads of general medicine, homœopathy stands to-day as the oldest system now practiced. Of all the rising and falling theories and fashions of medicine, not one of them has sent forth so many pages of valuable literature, investigated the properties of so many drugs, built so many hospitals, prevented so much sickness and suffering, cured so many diseases or saved so many lives.

This year she is celebrating her one hundredth anniversary; and what a celebration it is! There is no pomp and pageantry, no rearing of triumphal arches, no flaunting of banners, no pæans of victory, no shouts of triumph. There are no strains of music, no wreaths of evergreen, no garlands of flowers. Instead of these things, her sappers and miners, with spade and pickaxe, are laying bare her foundations and exposing them again to the light of day. They are turning upon her walls the blazing sun-glare of modern science, and noting if time and trial have disclosed weakness in her structure, and whether the descending rains of criticism and calumny, or the mad floods of persecution have availed to undermine the granite rock of truth on which she rests. In a word, this celebration is once

more examining the basis of her doctrines in the light of the century's knowledge and experience and once again demanding to know whether these doctrines are rational and logical, whether they can be demonstrated by physical experimentation, and whether they will avail as a faithful guide in the work of alleviating and curing disease and saving human life. Such is homœopathy's celebration of her first centennial. What medical system of the past ever provided such a birthday celebration? What other system of the present would dare to do it?

You stand, gentlemen, not only at the close of the old century, but at the opening of the new. What honor is yours in being permitted to participate in its progress, its struggles and its victories! Men of the Centennial: keep your faces to the future.

Joyous as this occasion is, its brightness is dimmed by the shadow of the great bereavement that has so recently fallen upon the college in the loss of our beloved and honored dean. Since the opening of this session he has been removed from the scene of his earthly labors. What those labors were during the twenty-one years of his deanship—how untiring and self-sacrificing; how far-seeing and far-reaching; how full of present results and how promising of coming fruition—we know it all; we feel it all now, as we did not, perhaps, while he remained with us. Who can forget his magnetic presence, his beaming face, his almost youthful enthusiasm as he entered into the spirit of these commencement occasions, his cheery words to the departing graduate, and the big, kindly heart that throbbed beneath it all? You, gentlemen, looked up to him with reverence, as to a father; do you know that so also did we, the members of his faculty, and that we leaned on him, knowing how strong he was? His labor is finished, yet his work goes on. The institution that he loved, and for which he wrought, how it grew under his hand; and from the nutritive impulse it received from him, it will go on growing still. In college halls and councils his name and work and worth will remain illustrious. No man can take his crown; none other wear the honor that so peculiarly pertains to him. That you, as physicians, should take him as your model, that in your professional lives you should develop much of his character and reflect much of his spirit, is to you our best farewell.

## SUMMER DIARRHŒA IN CHILDREN.

BY MARTIN DESCHERE, M.D., NEW YORK.

(Read before the Interstate Homœopathic Medical Association.)

THE term "Summer Diarrhoea" logically applies to a condition caused by the direct influence of the heat characteristic of that season, and occurring almost exclusively during that time. Two pathological varieties, entero-colitis and cholera infantum, represent this affection collectively.

Modern research has found a common cause for the two, formerly separately treated pathological states, and has laid a more plausible and natural basis for them. Hitherto observers differed as to the post-mortem appearances of cholera infantum, some holding that no visible changes could be found in the alimentary tract which pointed to inflammation, while others claimed the contrary. To-day it is held that cholera infantum and entero-colitis differ only in regard to acuteness of duration and termination, the former being extremely rapid and destructive, the latter being of a more subacute nature, sometimes passing into a chronic form; but both depending upon a common source, milk infection.

Prof. Voughan, of Ann Arbor, Mich., substantiates this view with very accurate data, and he comes to the conclusion that the toxicogenic germs grow and multiply in the milk both before and after it has been taken into the alimentary canal of the child, and elaborate chemical poisons which induce the diarrhoea and other untoward symptoms. The variety of the poisons is probably as great as that of the bacteria which produce them. While they may differ in the intensity of their toxic properties, all are gastro-intestinal irritants, just as we have a number of metallic poisons which act in a similar manner. Some of these poisons have been isolated and studied. Tyrotoxicon, first found in cheese, later in ice cream and other milk products, has been isolated from a sample of milk, a part of which had been administered to a healthy child and had caused a severe choleriform diarrhoea. This is a most potent poison, inducing severe and continued vomiting and purging, with speedy prostration, and death within a few hours if the

quantity administered is sufficient. Post-mortem examination shows but little change. The mucous membrane of the small intestine is bleached and softened, and possibly deprived here and there of its superficial epithelium. These are the symptoms and the post-mortem appearances of the cholericiform diarrhoea of infants.

With our present knowledge of infected milk and the chemical poisons which may be generated therein, the cause of summer diarrhoea in infancy has been divested of the mystery which formerly obscured our views. Uninfected milk improperly administered may cause intestinal indigestion, and thus prepare the way for milk infection; but it can never induce the severer forms of diarrhoea which make infantile mortality so alarmingly great. "The relation between these forms of diarrhoea may be likened to that between catching cold and infection with tuberculosis," says Voughan. "The popular idea is that tuberculosis originates in frequent colds, but the physician knows that this is not true, and that the only causal relation between the two is that which grows out of the lowered vitality, lessened resistance, and greater susceptibility. If parents were willing to pay for wholesome, uninfected milk half the fancy price which they readily give for some prepared baby food, their children would be better nourished and disease among them would be less frequent."

According to the investigations of Baginsky, Booker, Escherich and Jeffries, the intestinal contents during foetal life are sterile, and remain so for a short time after birth. However, within a few hours after birth bacteria find their way into the intestines. The meconium contains quite constantly two species of bacilli and a micrococcus. However, these bacteria wholly disappear with the last passage of meconium.

The normal bacterial flora of the healthy nursing child is yet more limited, so far as species are concerned, the number being two, the bacterium lactis aerogenes and the bacterium coli commune. These are known as obligatory "milk faeces" bacteria, and are constantly present. The small intestines form their normal abode. Other "inconstant" bacterial varieties are found in the large intestines of the healthy milk-fed child. "Whether any of these ever develop pathogenetic properties in diseased conditions or not is a question which has been

much discussed, but which cannot be considered as positively settled at present." (Voughan.)

The contents of the intestines in the so-called summer diarrhœas of infancy swarm with bacteria of many species, and some of these produce most powerful poisons. These bacteria multiply outside of the body, and are disseminated widely and abundantly only when the atmospheric temperature reaches 60° F. or higher. This is the reason for the restriction of these diarrhœas to the hot months of summer.

The symptoms of the affections known under the names of cholera infantum and entero-colitis are too well understood to require enumerating here.

With reference to differential diagnosis there is only one disease with which cholera infantum, or "acute milk poisoning," may be confounded, Asiatic cholera, and in times when this is epidemic it will be impossible to differentiate between the two without a microscopical examination of the stools. At all other times the suddenness of the onset, the incessant vomiting, the frequent watery evacuations of the bowels, and the rapid prostration are typical enough to enable one to make a correct diagnosis. Some writers have found cholera infantum to resemble sunstroke, and the points of similarity were given in the suddenness of the prostration, the high body-temperature, and occasional vomiting and purging. The prostration from sunstroke is sudden, while in milk infection it does not take place until after some hours, and the evacuations from above and below are by no means frequent, nor are the stools ever serous. The tendency to confound these two conditions arose from our former ignorance of the powerful poisons which may be elaborated in milk, and this view therefore cannot be sustained any longer.

Entero-colitis, or "subacute milk infection," is distinguished from the acute form by the milder character of the former. Vomiting and purging are much milder, the stools are of a faecal nature and not purely serous, the temperature does not rise as high, and the prostration is neither as sudden nor as great. Intussusception of the bowels may be distinguished by the suddenness and violence of the attack, the tenesmus and pain, the absence of fever, and the sterco-raceous vomiting, characteristic of this condition.

The most important point in the treatment of summer diarrhoea, acute or subacute, is the diet. As Escherich has demonstrated that the varieties of the bacteria in the infant's intestines change radically and speedily when milk is excluded from the diet, all milk food should be prohibited for from two to four days, possibly longer. In fact, this is one of the most potent agents at our command for destroying toxicogenic germs in the intestines. Their best culture-medium is milk, and in this they will thrive and multiply most abundantly. By excluding milk the effective and fertile soil for their propagation is withdrawn, and the organism is thrown upon its own resources to react against the poison so far absorbed. In this effort it will be best sustained by the aid of the carefully adapted homeopathic remedy. But before speaking of the medicinal treatment, permit me to indicate the plan of diet which I have followed successfully for the last twenty years, and which I am glad to have substantiated by the results of bacteriological research. My first rule is to discard at once the feeding-bottle used for the child to be treated, especially if it is of the kind supplied with rubber tubing inside, for these are the worst for cleansing, consequently they form the very resources for the breeding of milk poisons. The new bottle is to contain a mixture of equal parts of the white of a fresh egg and cold boiled water, barely sweetened with sugar, and the infant is allowed to drink as much of this as it pleases, but in one or two hour intervals. If thirst is excessive, as it most generally is in cases of summer diarrhoea, I dilute the egg with a greater quantity of water, say, one to three, and allow this to be taken more frequently. But nothing else must be administered in the way of food until a marked improvement is manifest; then mutton-broth, from which every particle of fat has been removed, is given between the egg-albumin feedings twice a day. It is best to add well-cooked barley-gruel to the broth and have all of it strained before feeding. Thus the carbo-hydrates will be sufficiently supplied, and after the vomiting has been overcome they will be well digested. This diet is kept up until the functions of the digestive organs are in normal working order, before milk is again permitted; for this, after all, will be the main food for a healthy infant.

Another point to be observed is absolute cleanliness of the

child's body, by sponging it with tepid water twice daily. This will be quite useful when the body-temperature runs high. But cleanliness is most important in regard to the diapers, which should be placed into disinfecting fluid the moment they have been removed from the patient. Also the mother's or nurse's hands must be disinfected immediately after having handled the infected clothing, for otherwise there would be an open door for the contamination of the food prepared by the same person.

After the storm has passed, and the bright sunshine of health again smiles upon the household, the greatest care must be observed in the preparation of the infant's food. Milk should never be used unless sterilized, or pasteurized, and regularity in time as to feeding will have to be strictly enforced. Substitutes for mother's milk, which swarm the market, should be avoided if possible, and should only be resorted to in cases where milk in a simply diluted form is not well digested. But in such instances I have seen good results from cream-mixtures. The proportions depend entirely upon the age and strength of the child, and can not be well specified for each individual case. It is well, however, to begin with one part of cream to ten of water, gradually adding milk by replacing one part of water by one of milk, until we reach a proportion of one part of cream, six of milk, and four of water. Two drachms of milk-sugar to every six ounces of the mixture will help to make the food more normal.

It is self-evident that the patient should be in the open air as much as possible, and that, if his home surroundings are unsanitary, he be entirely removed to more suitable quarters. With reference to this I generally advise change to the sea-shore from inland places, or to the mountains from the sea-coast.

The remedies indicated in acute and sub-acute milk-infection are not many, but they have well stood the test of time, and will act promptly when carefully selected.

For the acute form we must look to quickly-acting drugs presenting the violent character of poisoning which we have to deal with in our patients. One of the most frequently indicated remedies is *aethusa cynapium*. I have rarely seen *ipecacuanha* of much, if any, use in the beginning of true cholera infantum. But *aethusa* presents the rapid prostration, the absolute intoler-

ance of milk in any form, and the serous diarrhoea. The stools may consist of a light yellow or greenish water at first, and may contain undigested particles, as we also find in the first evacuations in the disease under consideration. But they soon become quite fluid, of a grayish-green color, and inodorous, and are followed by exhaustion. The vomiting occurs suddenly, immediately after nursing. It is violent, and consists either of the milk in the form in which it had just been swallowed, or, what is more frequently the case, the vomited matter comes up in thick curds, sometimes so large as to almost choke the child. Sometimes, a frothy, milky-white substance is thrown up, often without apparent nausea. The vomiting is likewise followed by profound prostration and a soporous condition, which gradually changes into actual stupor. This is only interrupted by the constant thirst, the satisfaction of which again produces the train of symptoms just described. The child's face presents an expression of anguish, and rapidly collapses, with especially marked deep lines running from the alæ nasi around the corners of the mouth.

The surface of the body is cold and covered with a clammy sweat. The involvement of the nerve-centres soon becomes manifest by convulsions, with dilated, fixed pupils, staring eyes, which are turned downwards (a very marked symptom of this drug). There is foam at the mouth, the jaws are locked and the thumbs clenched. During intervals there may be painful contraction of the stomach, accompanied by spasmodic hic-cough.

Bell, in his work on diarrhoea, remarks: "*Aethusa* is suitable to a severe form of cholera infantum. It will usually be hardly able to complete the cure alone, but will need to be followed by an antipsoric; most frequently by *psorinum*, *sepia*, or *sulphur*." To these remedies I should add *calc. carb.* I know, however, that *aethusa* will just do everything that can be desired to save the life under such desperate conditions as I pictured in the foregoing lines, and what remains to be done is simply to assist nature in its efforts to repair. What remedy will always cure any case alone, especially if it is of such deeply penetrating and rapidly destructive nature as acute milk-poisoning?

The next in order is *veratrum album*. Violence and rapidity of action also characterize this remedy. The stools are gush-

ing, profuse, colorless, like rice-water, often inodorous, accompanied by cramps, which spread from the hands and feet all over the body. The least motion aggravates the vomiting, as well as the stools, prostrating the child, which becomes covered with cold perspiration. The coldness of the extremities is a marked characteristic of veratrum, and forms a keynote for its selection. Profuse discharges per os and anum, rapid prostration, cold sweat, especially on the forehead, and cold extremities, will be a good picture for our purpose.

We may have to differentiate this remedy from *podophyllum*. Here we also find the profuse, watery, gushing stools, each seeming to drain the child empty. The cold perspiration on the head, and the coldness of the body, the exhaustion after the stool, also resemble veratrum. But the *podophyllum* patient does not vomit as constantly, and presents rather more of an empty retching and gagging. His stools are painless when watery, and not aggravated by the least motion of the body. Again, *podophyllum* produces a constant restlessness, more like *arsen*. This is also marked in the sleep, during which there is constant moaning, with rolling of the head from side to side, and half-open eyes. Similar to *veratrum* are the violent cramps of the lower extremities, but they do not spread all over the body, and there is a tendency to yawning and stretching of the body at the same time. Considering these differences, it will not be difficult to make the distinction between the two remedies.

*Arsenicum album* will disappoint frequently, and a careful study of its pathogenesis will show the reason why.

*Cuprum arsenicosum* is a remedy deserving more attention than it has received. Cases presenting a prominence of convulsions, with the rapid prostration of *arsenicum*, the violent purging and vomiting, accompanied by intense blueness and coldness of the surface, with general cold sweat, cold breath, and collapse, certainly most grave conditions, have been reported cured by *cuprum arsenicosum*.

*Laurocerasus*, *ænothera biennis*, *carbolic acid* and *secale cornutum* have been recommended, but I have had no experience with them.

Of alcoholic stimulants I have seen little good. What could not be accomplished by prompt attention to hygienic measures

and the right remedy was neither reached by brandy or whiskey. But I have witnessed cases, which grew steadily worse notwithstanding stimulation, improve under close attention to the rules laid down in this paper. Should I meet a case in advanced collapse, where no decided indications could be gained, I would, as long as life were still flickering, trust to *camphor*, rubbing the body with strong tincture, and by giving small enemas of a solution of the tincture in hot water. At the same time a few pellets, saturated with the remedy, may be placed in the child's mouth, and this procedure repeated until reaction takes place. The power of *camphor* to antidote vegetable poisons, to which the toxicogenic bacteria of milk certainly belong, and the recommendation of this mode of treatment in Asiatic cholera by Hahnemann, may justify my endeavor of drawing your attention to this valuable drug.

The treatment of the subacute form of milk-poisoning, or entero-colitis, offers a much wider range for the application of homœopathic remedies than does the acute variety; but I must content myself with referring you to the above-mentioned work by Bell, which gives, by all means, the most exhaustive and accurate indications for a large number of drugs in all forms of diarrhoeal affections.

In conclusion, let me urge you not to despair in the most desperate cases, and, likewise, not to be too sanguine in the face of so destructive a malady as summer diarrhoea in children.

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#### HAHNEMANNIANA, No. 3.

BY THOMAS LINDSLEY BRADFORD, M.D., PHILADELPHIA.

#### THE BUST BY DAVID OF ANGERS.

ON Thursday, June 28, 1876, at a session of the World's Homœopathic Convention, held at Philadelphia, in the Reformed Presbyterian Church, on Broad Street below Chestnut Street, Dr. I. T. Talbot, Chairman of the Committee on Foreign Correspondence, made the following report: "The Convention has received from the hands of Madame Hahnemann a colossal bronze bust of her former husband, the illustrious

founder of homœopathy, and she accompanies this with sentiments of deepest veneration for the memory of one who has done so much for humanity; of cordial sympathy with this Convention, which seeks to gather from all parts the means for the advancement of medical science," etc.

A telegram of thanks was sent to Madame Hahnemann, and resolutions of respect were passed "for her thoughtful and generous gift."

During the meetings of the World's Convention this great bronze face looked down on the representative homœopaths of the world from the platform of the quiet old church on Broad Street, in that Centennial summer week. Afterwards it was placed in the custody of the Hahnemann Medical College of Philadelphia.

This bust, a copy of which forms our frontispiece, now stands in the library of Hahnemann Medical College at Philadelphia on a raised arch, while beneath it, on the massive mantel-piece, is a life-sized cast of Hering's rugged face, and on either side are busts of Henry N. Guernsey and J. K. Lee.

The present picture was made from a photograph taken in 1893 by direction of Dr. Pemberton Dudley, at that time Secretary of the American Institute of Homœopathy, who used the picture as a model for the new seal adopted by the Institute at that time.

This bust is heroic in size, is of bronze, and the base bears the legend: "David d'Angers, 1837." We hear so much of the bust by David and the medallions by David that a few words as to that sculptor may not be amiss.

Jean Pierre David (1789-1856), better known as David of Angers, and who signed his numerous works "David d'Angers," must not be confounded with the painter David of the French Revolution, who was a part of that turbulent period. David of Angers made no paintings, but is renowned for his many statues and medallions. It is said that he made five hundred medallions alone.

When Madame Hahnemann took the old Master to Paris, she introduced to him her artist friends, among them David, then at the zenith of his fame. He had modelled the busts of many celebrated men, and from 1835 to 1840 made several busts and medallions of Hahnemann. The one in the college

is the original bronze by that artist. The editor of the *Volksblatter f. Hom. Heilverfahren*, in 1839 (vol. v., p. 105), says: "Hahnemann's bust in bas relief, in plaster, can be bought at Prof. Doll's, in Gotha, for six groschen. It is the only really faithful likeness in half-life size, and is modelled after an original in bronze, which was designed by the celebrated sculptor, David, in Paris, from which was also executed Hahnemann's large bust in Carrara marble, and which was presented by the physicians and friends of Hahnemann in Paris on the 19th of February, amid suitable and honorable festivities, to the Nestor of German physicians."

The bronze whose picture we present is most likely the great original bronze Dr. Wahrhold mentions, and from which the marble bust was fashioned. The celebration of February 19th was that of his eighty-third birthday.

There are in the United States several authenticated medallions signed by the same artist, notably one sent by Madame Hahnemann to M. d'Herville, her brother, who was then living in New York, and who, later, became a patient of Dr. Lippe, in Philadelphia. It is about seven inches in size, and the head is like that in the large bust. The David bust is the basis for the many plaster casts of Hahnemann that have been made in this country. David also made a large marble bust which was, at the celebration of Hahnemann's eighty-third birthday, ornamented with wreaths of the flowers of the belladonna, cicuta and digitalis, and which bore a golden crown of laurel. David himself, as a zealous adherent of homœopathy, was present at this festival. This bust remained in the possession of Madame Hahnemann, and after the death of that lady became the property of her adopted daughter, Madame Bœnninghausen. The celebrated actress, Mrs. Mowatt, who visited Hahnemann in 1839, says that every room contained several marble busts of Hahnemann, some much larger than life, some as large and some smaller. Dr. Henry Detwiller, going to Hahnemann for aid for the Allentown Academy, tells us that Hahnemann could not give him money, but promised him a marble bust by David, which bust was lost at sea. Dr. J. A. Campbell, who visited Madame Hahnemann in 1878, mentions that great marble bust by David. All the medallions and busts by David resemble each other, and, as David was one of the most noted artists of his time, and a

warm friend of the Master, it is quite probable that in the great David bust we see the head of the old physician as he looked during the last days of his life in Paris. It is recognized as being very truthful. When Hahnemann received word of his election as an honorary member of the New York Medical Society, in a letter written to him by Dr. John F. Gray, of New York, he sent Dr. Gray a letter and also a bust by David, and it is this bust that Mr. Niehaus, the sculptor of the monument of Hahnemann soon to be erected in Washington, has used as a model. Dr. H. M. Smith writes: "Regarding the David bust; the one I have, and which Niehaus copied, is of plaster, and was sent by Hahnemann to Dr. Gray in reply, I think, to Dr. Gray's notification of Hahnemann's election to membership in the New York Medical Society. I got the bust from Dr. Gray."

There is little doubt that the unusually high forehead, firm features and resolute mouth that characterize all the busts and medallions fashioned by David, correctly represent Hahnemann in later life.

And it is a happy inspiration that led Mr. Niehaus to copy for the Washington monument the great dome of forehead, the lined face and scholarly look of repose after storm that is seen in the bust by David.

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## CARBUNCLE.

BY CARL V. VISCHER, M.D., PHILADELPHIA.

(Read before the A. R. Thomas Club, February, 1896.)

THIS subject has suggested itself to my mind as being worthy of consideration, inasmuch as it is of common occurrence, and as there is a tendency on the part of many to adhere to methods of treatment not at all in accord with the more recent and accepted principles of surgical therapeutics.

By carbuncle, as the term is now used, is understood an infection of pus-microbes, and differs from a furuncle only in that it consists of a number of foci of suppuration that develop either simultaneously or in rapid succession and become con-

fluent; therefore, must not be confounded with malignant pustule, which, in many of the text-books, particularly those of a few years ago, is used synonymously with carbuncle, but differs from it in that it is caused by a specific bacterium, the bacillus anthracis, and which begins from a single centre of infection, and is always accompanied by a rapid necrosis of the overlying skin, besides the general symptoms, which are more pronounced, and lead rapidly to a fatal termination in the majority of instances.

Pathologically, a carbuncle is composed of numerous foci of suppuration or necrosis, owing to the extensive infection of pus micro-organisms which bear a direct relation to the suppuration or necrosis. In the former, the infection being less, changes identical to an ordinary suppurative inflammation take place. In the latter, where the infection is greater, necrosis occurs from the great number of bacteria, *i.e.*, from their mechanical effect interfering with the nutriment of the part, and also from the toxines set free before there has been time for inflammatory changes to become established. Consequently, the more acute the carbuncle, that is, the more rapid in its development, the less pus there is apt to be, in the place of which is found sloughs or necrotic masses of connective tissue. The infection is generally limited to the skin and sub-integumentary connective tissue, and tends toward peripheral infiltration, though at times it may involve the deeper structures. The infection may take place at any point, though most commonly it occurs at the back of the neck, between the shoulders, the face and on the buttocks. It begins as a small circumscribed area of inflammation, which rapidly increases in size to that of a quarter of a dollar, and may vary from this to that of a large plate. The skin and subcutaneous tissue is found greatly infiltrated, giving a peculiar hard sensation to the examining fingers. The skin, which at first is of a bright red, gradually becomes darker, assuming ultimately a purple or black color, which is more marked in the centre, and gradually fades toward the periphery. This is soon followed by the development of one or more small openings having a crater-like formation, and through which exudes a thick creamy pus or small sloughs of connective tissue, and which gradually coalesce as the intervening skin becomes necrotic. The condition now is changed from a swelling,

which gradually fades into the surrounding tissue, and which is perforated about the apex, to one of a less degree of tumefaction, with a large opening in the centre which has inverted edges, due to undermining of the skin, and whose base is of a gangrenous appearance. The openings always develop about the centre of the carbuncle, for the reason that it is here that the greatest infiltration is found; hence, the greatest impairment of nutrition, and naturally the first to break down. These changes are accompanied or soon followed by symptoms evincing a general systemic involvement, and may vary from those of a septic intoxication to those of pyæmia. The subjective symptoms due to the local change are but few, and such as accompany any acute inflammation, save that an intense burning pain is commonly complained of, making it quite characteristic of the disease.

Carbuncle, as other diseases of an infectious nature, has a predilection for those whose power of resistance is below the normal; hence, those suffering from chronic nephritis, alcoholism and particularly diabetes, and is, in consequence, to be found oftener in those advanced in years than in the youthful. The prognosis depends much upon the general condition of the patient, the degree and site of the infection, and may thus vary from that of being favorable to one of decided gravity, if not lethal.

*Treatment.*—The treatment of carbuncle has, from time almost immemorial, been that of poulticing, and it is this fact in particular that has led to the creation of this paper, giving the writer a much desired opportunity to raise his voice and hands in earnest supplication and emphatic protest to the time-honored flaxseed, bread and milk and all similar substances for poultices, in this as well as any and all inflammatory changes. Poultices, that is, the application of heat either dry or moist, are of undisputed value in certain stages of many inflammatory conditions, and I for one should not desire to disparage their employment. But let us by all means be consistent, and not frustrate our object by applying means which favor the development and propagation of the principal factor in the aetiology of the disease. It is a well-known fact that heat and moisture favor the development of bacteria; and if to these be added additional bacteria, which is inevitably done by the application

of such substances as above mentioned when applied in the ordinary manner, is there anything surprising in the fact that without exception the existing condition becomes increased until such a time as when the natural laws of self-limitation assert themselves?

If we consider for a moment the changes occurring in inflammation, we can readily comprehend why it is that either hot or cold applications are indicated but for a limited time, and if continued beyond this, prove of positive harm. The first change of any permanency occurring in inflammation is a dilatation of the vessels, and it is here that applications of ice are most beneficial, inasmuch as they tend toward re-establishing the tonus of the vessel walls, and in consequence cause a contraction which clears the capillaries and prevents further mural implantation, *i.e.*, exudation. Secondly, micro-organisms can only multiply at a certain temperature; hence, if this can be kept at a point sufficiently low to prevent their increase in the inflamed tissue, much has been gained. Ice acts at least in an inhibitory manner and thus fulfils one of the causal indications in the treatment of inflammation. When, however, stasis has already taken place, ice proves harmful, as it interferes with the development of a proper collateral circulation. It is therefore only indicated in the earliest stage of inflammatory conditions. In the later stages, after stasis has occurred, hot applications may prove beneficial, in that they stimulate the development of collateral circulation, consequently absorption; but as a rule this can be accomplished more readily by other means devoid of the dangers accompanying the continued use of hot dressings. Hot fomentations came into vogue at a time when it was thought advisable to hasten suppurative processes, and this they do beyond all doubt. The present state of our knowledge, however, as to the reparative processes being such as to show the uselessness, yea, the dangers, of inducing suppuration to clear a tissue of inflammatory infiltration, of necessity regulates the continued use of heat to the past.

Changes of an infectious nature, as all others, are most successfully combated by the removal of the cause; this of course is the most rational. Unfortunately, however, the cause is frequently unattainable, or is so only at an unwarrantable sacrifice. Yet in some instances we are capable of removing the cause by

having resource to methods that are less dangerous than allowing it to continue in its effect. In other words, we choose the lesser of two evils; carbuncle is one of these instances.

When seen in its very incipiency, applications of ice prove of great benefit, for reasons previously stated. In the majority of instances, however, a carbuncle is not seen until tissue changes have become more or less marked, and therefore past the stage where cold is of much, if any, advantage. It is here where parenchymatous injections of carbolic acid from 3 per cent. solutions upwards, as first suggested by Bidder, prove of great value, inasmuch as they destroy the cause and "set up a healthy action," if you please; the causative factor having been removed, changes identical to healthy resolution take place, and at times with remarkable rapidity.

Where retrogressive changes are about to take place, or have already begun, free incisions and the removal of the "core" or pus is indicated, after which the surface should be thoroughly wiped with crude carbolic acid and compresses wrung out of carbolic acid solutions 1 : 20, or substances of equal germicidal power applied.

This soon converts the infected area into a healthy granulating wound, which is again in turn treated according to anti-septic principles. In cases of extensive carbuncular infection the same principle is practiced, except more extensively—numerous and free incisions followed by curettement and cauterization, or, as some Germans have recently recommended, by free and complete excision of the infected area; this latter procedure is oftentimes impossible or impracticable, owing to the size or site of the infection, when the lesser heroic measures are indicated. In carbuncles of large size it is often desirable to skin graft in order to prevent subsequent cicatricial contractures. In cases of multiple infection the various stages of the same principle of treatment may be carried out at the same time. Next in importance—in cases of large carbuncles—to removing the seat of infection, is the attention to the general condition of the patient, who frequently presents symptoms of septic intoxication or infection; these are best met by stimulating diet and the administration of such remedies as, particularly, cinchona and arsenic, and the many well-known remedies indicated in condition of blood disintegration.

## THE TREATMENT OF SPECIFIC URETHRITIS—A PLEA FOR ABORTIVE METHODS.

BY L. T. ASHCRAFT, A.M., M.D., PHILADELPHIA, PA.

(Read before the Philadelphia County Medical Society, March 12, 1896.)

SINCE the concensus of medical opinion favors the gonococci of Neisser as the cause of specific urethritis, it would seem rational that the treatment should consist, primarily, in the employment of any agent that will destroy the gonococci and, secondarily, the prevention of complications and the restoration of the urethral tissue to a normal condition.

Although urethral discharges are usually spoken of as infectious and non-infectious, yet, like other organs and tissues of our body, the urethral mucous membrane may admit of several distinct and separate pathological conditions, among which are urethritis tuberculosa; syphilitic urethritis; bastard gonorrhœa and pseudo-gonorrhœa, any one of which may present certain symptoms resembling the special variety now under discussion.

That intelligent treatment may be instituted it becomes necessary to exclude any of the foregoing varieties, determining the diagnosis of specific urethritis upon the clinical symptoms or, if necessary, by the employment of the microscope to prove the presence of the gonococci of Neisser. The symptoms are too well known to discuss.

Acute specific urethritis is an inflammation. Pus containing gonococci is deposited upon the mucous membrane of the fossa-navicularis. This results in an acute hyperæmia and inflammation with increased glandular secretion. An examination of the urethra by means of an endoscope discloses swelling of the mucous membrane, which is covered with a muco-purulent secretion. Occasionally erosions and ulcerations are seen.

While an attack of acute infectious urethritis rarely results fatally, yet cases are recorded that have succumbed to it, because of an extension of the inflammatory process from the posterior urethra and prostate to the bladder or kidney.

The tendency of all tissue is to resist injury. So with the urethra, but just how long a time is required to effect a cure is

influenced by rational treatment. There is a marked tendency to chronicity. An attack, untreated, lasts from four to six weeks, after which time it becomes chronic.

The treatment suggests a strict observance of the following: prophylaxis, hygiene, cleanliness, diet, medicine (local and internal), and surgical procedures.

Among the prophylactic measures advised are: continence, cleanliness and isolation of infected cases. The hygienic and dietetic treatment should be most rigid. The diet should be light, unirritating and nourishing. No tea, coffee, asparagus, strawberries, salads, or highly-seasoned food, in immoderate quantities, should be indulged the patient. Alcoholic beverages must be interdicted positively, except to those who have been accustomed, habitually, to stimulants. The ingestion of large quantities of pure water and rest of both body and organ are procedures that cannot be too highly lauded. Rest in bed during the first week of an attack frequently wards off complications which might otherwise occur. The wrappings around the penis should be light and cleanly. While there are those in all schools of medicine who warmly advocate the employment of remedies administered internally, clinical experience demonstrates that such is not the ideal method of curing urethritis. By medicines administered per orem we can hope to effect a cure only through the medium of the urine. Acute specific urethritis is a purely local disease; one due to a well-recognized germ. This being true, it is only rational to effect a cure by germicides locally applied. I do not wish to be misunderstood; I say most positively that gonorrhœa can be cured by well-selected homœopathic remedies. In urethritis of a non-specific character or acute outbreaks or uncured conditions the indicated remedies act most brilliantly. Among those having proved of good clinical service are aconite, gelsemium, capsicum, cantharis, cannabis sativa, nux vomica, sulphur and thuja. The employment of some internal antiseptic such as salol or boracic acid is often advisable, the end in view being to sterilize the urine.

Among the remedies that have been employed successfully in specific urethritis are mercurius, copaiba, ichthyol, kreosotum and terebinthina. These remedies are best administered together with some local application.

Since local treatment is most employed, a description of the various methods, together with some of the remedial agents that have proved of value, should be interesting.

The urethra is treated locally by six methods:

The simple injection, continuous irrigation, retrojection, instillation, endoscope and by surgical procedures.

Treatment by instillation and by the endoscope are rarely resorted to save in cases that show a tendency to become chronic and invade the posterior urethra. The simple injection method is the most popular. The patient, in order to receive the injection, should lie down, and the fluid be allowed to flow in. Care should be taken not to throw the fluid forcibly, as infection of the posterior urethra might result. If the patient uses the syringe, he should make pressure upon the perineum by means of a towel; otherwise, the procedure is the same. Simple injections are of great service in all stages of urethritis, save when a high degree of inflammation exists, when the method known as continuous irrigation should be substituted. Its advantages over the simple injection method are, that two or more quarts can be used at one sitting, and it insures a thorough washing out of the anterior urethra.

Continuous irrigation may be either superficial or deep. Having previously urinated, the patient is placed in the supine position, or he may be allowed to stand. A quart bottle or jar, with a spigot or other suitable outlet near the base, is fitted with a piece of rubber-tubing about two yards long. A Kieffer two-way tube is attached, and five inches of pipe are placed on the free fork. The tube connecting the reservoir with the Kieffer nozzle is compressed with an artery clip, and the bowl is ready to receive the selected solution. When in use, the reservoir is placed upon an elevated shelf or table, or, better still, held high by an assistant, while the surgeon inserts the tube into the meatus, releases the pressure on the pipe by removing the clip, and the process of continuous irrigation is at once under way.

The hot retrojection method is the ideal treatment. Its advantages over all other methods are:

1. It can be used at all stages of the disease.
2. It can be used several times a day.
3. It produces very little irritation.

**4. It thoroughly cleanses the canal.**

A specially devised instrument is used to give this treatment: A soft rubber catheter is securely attached to the pipe of an ordinary fountain syringe. The pipe is stopped with an artery clip, and the reservoir of the syringe is fixed at an elevation of five feet. The patient seats himself on the edge of a chair, over a large vessel; the catheter is passed five inches into the urethra, while an assistant fills the reservoir of the syringe with the hot fluid to be used. The pressure is removed from the pipe, starting the current, and the treatment progresses.

The preparations used locally in the treatment of urethral inflammations are legion—from an element so simple as water to the most difficult compounds. It is only necessary to be familiar with those that have proved of clinical value.

Water, either hot or cold, is the simplest. It is used hot preferably, and can be employed in all stages—invasion, inflammation and decline. It possesses the advantages of cheapness and cleanliness. The best way to employ water is by the hot retrojection method, although it is frequently used by the simple injection and continuous irrigation methods. It is largely efficacious in subduing inflammation.

The next remedial agent of undoubted value, one that can be used by all methods of treating the urethra, and one, the clinical value of which no one can dispute, is the bichloride of mercury. The strength used must suit the case, usually about 1 to 10,000. It is best used by the method of continuous irrigation. It can be used in all stages and in large quantities.

Permanganate of potash is an antiseptic of undoubted clinical value because of its oxidizing effect. It should be employed only in the stages of invasion and decline. The best method of applying this agent is by the simple injection process, in strength of one-half grain to four ounces. It can be given in strength of one part to two or three thousand by continuous irrigation or retrojection.

Cotes, of London, first used nitrate of silver in the treatment of acute specific urethritis. His method consisted in applying, by means of an endoscope and a cotton swab, a solution of nitrate of silver of 10 to 20 grains to the ounce. He claims to have been successful in his efforts to abort gonorrhœa.

The consensus of opinion among the members of the medi-

cal profession is largely against the employment of the drug, because of the inflammation, pain and possibility of stricture resulting. It should be employed only by means of the simple injection method. At the suggestion of my chief, Dr. Van Lennep, I used this salt upon the cases in the Genito-urinary department of the Hahnemann Hospital Dispensary, and as a result of experiments upon nearly two hundred carefully selected cases, a cure resulted in a majority within fourteen days, and apart from acute pain and *occasionally* the discharge of a little blood, no complications arose.

The success of this treatment depends upon the strict observance of the following rules:

1. The patient must present himself when the discharge is muco-purulent in character. In other words, preferably, within the first two or three days of an attack.
2. The strength to be used should be a 4 per cent. solution (fresh) of nitrate of silver.
3. The amount from one to two drachms.
4. Frequency of employment usually twice—rarely oftener, confining the solution within the urethra fully five minutes.
5. The patient must be free from the permanent effects of a constitutional disease.
6. He must religiously observe the hygiene of urethral inflammations.

A *résumé* of the various methods of treatment necessitates, primarily, a thorough examination of the discharge. If it be muco-purulent, the patient receives nitrate of silver; if purulent, the indicated remedy and the method of continuous irrigation, retrojection or simple injection is employed, using the bichloride of mercury or permanganate of potash. He is cautioned to observe the hygienic rules indispensable to the successful treatment of urethral inflammations, and he may be considered cured:

1. When there is no discharge.
2. When the strings are absent or rise to the surface of the fluid voided, and contain no gonococci.
3. When neither stricture nor prostatitis exist.

A review of the symptoms, pathology, and prognosis of acute specific urethritis discloses the possibility of complications, such as stricture, prostatitis, posterior urethritis, cystitis, pyelitis,

and, remotely, death. Admitting this, and that acute specific urethritis is a purely local disease (in the first few days of an attack confined to the anterior urethra); that it is caused by a known germ; that this germ can be destroyed by the local methods just mentioned, the abortive treatment is the rational treatment.

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### THREE CASES OF TUBAL PREGNANCY OPERATED AT THE HAHN-MÄNN HOSPITAL OF PHILADELPHIA.

BY THEODORE J. GRAMM, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

OF all the anomalous conditions included in the pathology of pregnancy, there is none which has a more urgent importance for the general practitioner than ectopic gestation; for it is to him that the cases usually first come. The life or subsequent health of the patient is often dependent upon the measure of his skill in recognizing them and instituting proper surgical treatment at the time when it is most successful. Later, when secondary rupture has taken place, the case is distinctly recognized as one for the abdominal surgeon, and the diagnosis of a grave pelvic trouble is easier, but the prognosis is very much more uncertain. I wish to insist, therefore, upon the urgent necessity for every physician, especially those in general practice, of being conversant with the early symptoms of ectopic pregnancy in order that overwhelming disaster may not only be averted from many patients, but also that they may have the prompt benefit of abdominal surgery so splendidly developed within very recent years.

Ectopic pregnancy is a pathological condition which is by no means of rare occurrence. I sometimes wonder whether my impression be correct, that there are still some who do not realize that fact. At times it appears that this is regarded as an anomaly whose chances of occurrence are quite remote—as a subject of interest for the abdominal surgeon only—as a curiosity of which some one has had “another case to report.” The literature of our school, I regret to say, might contain many more reports of cases of ectopic pregnancy and of discus-

sions concerning the early recognition of this condition, which should have such an active, vital, *alarming* interest for the general practitioner; for it matters not what may be the social condition of his clientele, or how remote from abdominal surgery his practice may be, he is likely at any time to come in contact with a case of ectopic pregnancy.

The fact of three cases of tubal pregnancy coming to the hospital during the past summer, within almost a few days of each other, would verify the statement that this pathological condition of pregnancy occurs oftener than some might be inclined to believe. The previous symptoms, the operations, and the subsequent microscopic examinations have removed every possible doubt as to this correct diagnosis. These cases have an interest likewise in being cases wherein the early stages of ectopic pregnancy are admirably portrayed.

The first case is one which was operated before the tube had time to rupture. The second case is one of *tubal abortion*—that is, the ovum was primarily lodged in the outer third of the tube, and the fimbriated extremity of the tube not being closed until the eighth week, as is usual, the ovum was extruded into the peritoneal cavity with free blood. The fimbriated extremity was open and dilated, and showed distinctly where the ovum had been lodged. This case, therefore, was in the same condition as one would be, wherein secondary rupture had taken place a few days before operation. In the third case a number of days had elapsed between the rupture of the tube and the abdominal section. The first case has a special interest in that a positive diagnosis was made before the operation and prior to the rupture of the tube.

CASE I.—Mrs. M. B., æt. 27; no children; one miscarriage at seven months in May, 1889. Her previous history showed that menstruation occurred usually every twenty-eight days; the flow was bright red in color, scant in quantity, and lasted three days: there was some leucorrhœa, mucous in character, but was sometimes white in color and excoriating; the leucorrhœal discharge was increased before the menstrual period. She began to menstruate at æt. 15. She has never had any serious illness. The patient was admitted to the gynæcological ward of the Hahnemann Hospital on the afternoon of August 23, 1895, from the dispensary department, and was thought to





be suffering from an incomplete abortion. The hospital records say that until the last month the patient menstruated regularly every four weeks. At that time there was no "show" for a week after the usual time. At the end of the week, during the night, the patient was awakened by a gush of blood from the vagina. The discharge contained several particles resembling "flesh." Since then, that is August 15th, the patient has been flowing more or less freely; has been feverish; has had headache, nervousness, and some sensitiveness in the hypogastric region. The temperature on admission was  $99\frac{6}{10}$ ° F., and the pulse 80. She complained of having much pain in the back and bearing-down pains in each side of the abdomen, and occasionally very sharp cutting pains.

I saw the patient at my morning visit to the ward on the day following her admittance and made a vaginal examination. This revealed "the perineum normal, the cervix somewhat softened, the body of the uterus enlarged and directed forward. Right lateral region: In the posterior pelvis a soft mass 2 by  $2\frac{1}{2}$  inches in size. Left lateral region sensitive, but the adnexa not much thickened. Diagnosis: Extra-uterine pregnancy." The patient complained so little of pain and had had no evidences whatever of shock, that I determined to give her the benefit of the doubt and so on the following day had her taken to the amphitheatre and anæsthetized. A careful pelvic examination confirmed the conditions previously found, and my senior, Professor J. E. James, concurred in my opinion. The cervix was quite dilatable and I used a curette, but found the cavity of the uterus singularly free from every trace of membranous formation. An examination on the 28th of August showed the mass in the right pelvis to be growing perceptibly larger.

On August 30, 1895, I opened the abdomen, with the kindly assistance of Professor James. The operation presented no difficulties whatever and was completed in a few minutes. The recovery of the patient was rapid and altogether without incident.

I have the pleasure of exhibiting the specimen, and a photograph made from it of natural size, of this unruptured pregnant tube. (See plate).

CASE II.—Mrs. F. A., æt. 27; IV.-para; last childbirth in

April, 1894; no miscarriage. Menstruation every four weeks usually; the flow lasts four days and is bright red; she has some pain before the flow; no leucorrhœa.

Patient was admitted to the gynæcological ward on September 16, 1895. She then said that three weeks ago she was taken with quite severe cramp-like pains in the lower part of the abdomen running around to the back. At the same time the patient had quite a profuse bright red bloody vaginal discharge. The pains caused her to become sick at the stomach; they lasted three or four hours and left her feeling weak and numb in the left side. These pains returned at intervals.

The patient came to the dispensary and there her symptoms excited the suspicion of ectopic pregnancy, a suspicion which I was inclined to share after a vaginal examination. It was impossible however to be quite certain then because of the difficulty of examining the pelvis by reason of a rather large amount of fat in the abdominal walls and because of the absence of a clearly definable mass in the left pelvis. The probable nature of her trouble was explained to her, and she was advised to come to the hospital on observing the slightest suspicious symptom. I have reason to believe that a hæmorrhage took place that afternoon while she was going home.

She came to the hospital within a few days after this. On admission the patient complained only of numbness in the left thigh. Her temperature was 98.8° F. and the pulse 92. She had a bloody vaginal discharge. On the following morning I saw her and then a vaginal examination showed the perineum and cervix lacerated; the uterus to the right of the median line and behind the symphysis. The structures in the right side of the pelvis were apparently normal. In the left pelvis and behind the uterus was a doughy mass which was sensitive immediately behind the cervix. Examination per rectum confirmed the above. Diagnosis: Extra-uterine pregnancy.

The patient was kept in bed, and special directions were given that she be kept absolutely quiet. Occasionally she had sharp pains in the left side and at times she had some bloody vaginal discharge. Aside from this she was in a good condition and her temperature was about 99° F.

On September 20, 1895, Professor James and I operated her. We found that free hæmorrhage had taken place into the

peritoneal cavity filling the cul-de-sac of Douglas with dark clotted blood. The left tube was found ruptured (?) and was removed. The right tube was also removed, because it was inflamed, as also the right ovary, which was in a cystic condition.

The patient was returned to the ward in good condition and reacted well from the anaesthetic. Her recovery was good and without incident except that her temperature rose suddenly to 102° F. on the day following the operation before the bowels moved, but declined rapidly after that. The specimens from this case are likewise presented for your inspection.

CASE III. was a more formidable case. Mrs. M. B., æt. 23, V.-para; last child in May, 1891; one miscarriage at two months in 1886. Was admitted to the Hahnemann Hospital, on the night of September 5, 1895, and at 10.30 p.m., I saw her. Her previous history showed that she had had peritonitis following her last child-birth. Her menstrual periods occurred every twenty-eight days, lasted from three to five days, the flow being bright red, and was attended by very little pain. Leucorrhœa was present in moderate amount, was thick, white, and bland; it was increased before the catamenia.

I found the patient in a condition of serious collapse. She was pale; almost pulseless; her skin was cold; she complained of nausea, and vomited after taking a little water. Her temperature by the mouth was 97 $\frac{6}{10}$ ° F., and the pulse quite weak and 104. She also complained of severe cramp-like pains in the right side of the abdomen, and there was a bright red vaginal discharge.

The history which she gave the resident was that her menses were due on July 12th, but she had no show until the 29th. The flow then appeared natural, and lasted five days. The flow then ceased for a day and a half, when it again appeared profusely, the discharge being quite red. Since then there has been a bloody discharge, more or less profuse. Four weeks ago she had cramp-like pains in the lower abdomen and in the right ovarian region. About the middle of August she passed a clot about the size of a walnut, which the patient thought was placental in character. The attending physician thought she had miscarried, and gave morphia to control the pain. During all this time her appetite was much disturbed, and she had occasional attacks of vomiting.

A vaginal examination was made, and revealed the perineum lacerated. The os uteri was patulous, and was situated just behind the symphysis. The fundus uteri was apparently directed posteriorly, but, on subsequent examination was found to be continuous with the cervix in the right pelvis anteriorly. The entire left pelvis was filled by a semi-fluctuating mass, which displaced the uterus in the manner just named, and this mass likewise partly filled the right side of the pelvis. The cervix was found to be immovably fixed in the pelvis. The vaginal vault was much depressed and almost touched the coccyx behind. All about the cervix the intravaginal finger was met by this resisting and yet somewhat fluctuating mass. The abdomen externally presented, on palpation, this same sense of a resisting mass, which seemed to be almost continuous with the symphysis, and extended half-way up to the umbilicus.

I felt much inclined to operate the patient at once, but knowing that her ultimate chances would be greatly increased could she be made to react from her collapsed condition, restoratives were applied, and I ordered her to be quietly prepared for abdominal section on the following day. In the meanwhile, her pulse improved in character and the temperature rose to  $99\frac{6}{7}$ ° F.

She was operated with the assistance of my senior, Prof. James, in the clinic on the following day. An incision in the median line encountered extensive adhesions in every direction. These being separated, a large collection of partly fluid and clotted blood was encountered which filled the left side of the pelvis. About a pint of black clots and fluid blood was removed. The left tube was found much enlarged, doubled upon itself and ruptured; it was removed after ligation. The right tube, being also much thickened and inflamed, was removed, and the peritoneal cavity cleansed.

This extensive cavity remaining after removal of the clots and uterine adnexa, was packed with several strips of iodoform gauze about the glass drainage tube, and the patient returned to the ward, where she reacted well.

After operation, there was no marked rise of temperature, but considerable fluid drained through the dressings and tube. Because of this fact it was necessary to retain them longer

than usual, the tube being removed first and then about daily a strip of gauze. To the fact of being compelled to use a gauze drain for several days, is probably attributable the existence of a fistulous opening, about two inches deep, at the time of her discharge from the hospital, about six weeks later.

These cases illustrate, as I have said at the outset, the conditions existing in tubal pregnancy before, shortly after and some time subsequent to rupture of the tube. The ease with which the first case was operated, and the subsequent uninterrupted recovery of the patient, emphasize the advantages of recognizing and operating the cases early. In the other two cases, the relatively greater difficulties encountered, and the more extensive damage sustained by the pelvic structures, clearly indicate the added dangers and diminished chances of late operation.

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**COLLECTION OF PUS IN THE SPHENOIDAL SINUS, WITH THREATENING PRESSURE SYMPTOMS.**—Hajek (*Wiener Medizinische Wochenschrift*) reports the case of a man, *at. 45*, who for nine years had suffered with a profuse discharge of pus from the right nostril. In the last two or three years had had severe headache in the right temporal region, intensified on stooping over; with vertigo on again resuming the erect position. Numerous polypi almost occluded the right nostril, and made examination as to the source of discharge impossible. They were removed without relieving the symptoms or discovering the seat of the abscess cavity. Removal of anterior portion of middle turbinated gave considerable relief for but a short time. The remaining portion of turbinated was then removed, and a glistening, pulsating spot on the anterior wall of the sphenoid was discovered. A small sound introduced into this opening entered the sphenoidal sinus; two or three drops of thick pus followed the withdrawal of the sound. The opening was enlarged with forceps especially constructed for the purpose, a canula was introduced and the cavity washed out. Complete relief of symptoms followed, with the exception of the discharge, which ceased after curettage of the cavity with a sharp spoon.

**TREATMENT OF HYPERSTROPHY OF THE PROSTATE BY SECTION AND LIGATION OF THE SPERMATIC CORD.**—Isnardi has found that a simple measure—section of the spermatic cord, with consequent ligation of the central and peripheric ends—will fully replace castration in hypertrophy of the prostate. He has tried it in two cases. The first one, of cancer, is excluded. The second was a man of 72 years, who for two years had been affected with grave disturbances from a hypertrophic prostate, which had resisted the usual treatment. Operated on May 1st, he was completely cured by June 14th; the retention and incontinence of urine had completely disappeared. He could hold his urine easily for six to seven hours. The urine was clear and normal from all points of view, while formerly it contained blood and occasionally pus. The prostate could not be felt on rectal examination; the spermatic cord presented a slight node at the point of operation; the epididymus was decreased in size and cartilaginous in consistency, and, finally, the testicle was half its previous size—a result quite similar to inflammatory obliteration of the spermatic cord following gonorrhœal epididymitis.—*La Semaine Médicale.*

## CORRESPONDENCE.

## SIMILIA SIMILIBUS CURANTUR.

I HAVE read your editorial on the above in the April HAHNEMANNIAN MONTHLY with interest. It seems to me that in order to demonstrate the fact that "Similia Similibus Curantur" is the right and proper motto of our school it is necessary only to show that the "law of similars" is a "natural law." Hahnemann, probably not believing that such stress would be laid on the word "may" (which would render the meaning of the quotation doubtful)—"likes *may* be cured by likes" or "likes *may* be cured by likes," the latter without stress on the word may, states a fact just as dogmatically as the rendering, "likes are cured by likes." Is it not a splitting of hairs? Does not the meaning to be conveyed depend entirely on enunciation? If Hahnemann intended to convey that "likes *may* be cured by likes," it must be allowed that in his mind was the thought that they *may not*, and if we know anything of Hahnemann or of his *Organon*, we know that such was *not his belief*. As to our demonstrating that "Similia Similibus Curantur" is a "law of nature," and therefore an absolute law, it can be *mathematically* proved, as I have often done in practice and so also have many better men than I. To save your valuable space I will refer your readers to a paper of mine relating to this very question, which you published in the HAHNEMANNIAN MONTHLY for February, 1890, together with my plan for finding the remedy. It will be seen that if we select a remedy that will *cover the totality of symptoms*, that remedy *will* cure, in all curable cases, although we had not even thought of it before working it out; we are simply led to it by the fact that the drug selected produces in a healthy person *all* the symptoms of the disease treated. I would refer you to paragraphs 28, 29 and 48 of Hahnemann's *Organon*, and lastly I would quote the latter part of paragraph 54: "*The true homœopathic method of cure is the only correct, the only direct, and the only possible means to be employed by human skill, as surely as it is possible to draw but one straight line between two given points.*" [The italics are mine.]

I am, dear sir, yours very truly,

ALFRED HEATH, M.D.

114 Ebury Street, London.  
April 11, 1896.

## EDITORIAL.

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### PRIORITY AND PLAGIARISM.

PERHAPS one of the most obtrusive facts in the medical literature of the day is the evident desire of so many of the writers to establish the priority of their claims to some one thing or another. In one paper it is priority in the use of some word; in another priority in the recognition and description of some symptom-complex, or the suggestion of some particular line of treatment. In short, since it is not considered ethical for a physician regularly to patent any medical or surgical device, he endeavors to indemnify himself by establishing a sort of irregular copyright to his every idea. Often, on insufficient and illusive indications, he stakes off his claim and then proceeds to "work it," hoping to find gold, but sure only of having forestalled his colleagues in holding that particular spot. It may indeed yield the precious metal, but most frequently turns up nought but pyrite, if that.

Priority naturally suggests plagiarism, and this subject has been brought prominently before the public by two late instances, much commented upon by the press, in the interest of so-called morality. In the one, the popular minister of a rich and fashionable church in New York, under stress of manifold duties, preached a sermon not his own, which fact was quickly discovered and proclaimed by a loving but conscientious "brother in the Lord." In the other, a student in a university "cribbed" an article written by the president of the institution, and published it over his own name in the college magazine, of which he was an editor.

We refer to these things with no intention of deciding upon their ethical character, although we think, in spite of the principle *suum cuique*, there may be two views even upon that point. We would wish to speak only of the unconscious plagiarism of which we are all guilty. We are all, more or less, plagiarists. It would be difficult to imagine a person using an entire sermon or magazine article composed by another under the im-

pression that it was his own, and yet for one acquainted with the enigmas presented by psychic phenomena, it would not be altogether impossible to conceive of such a thing.

Solomon, in spite of the facilities afforded by the possession of 5000 wives, was obliged in a fit of overwhelming ennui to declare there was no new thing under the sun. Even now our novelties are but new combinations. Just as the total sum of energy in the universe is no greater than it was in the beginning, so the total number of eternal elementaries which lie at the basis of the innumerable ephemeral varieties, remains ever the same. We are therefore all obliged to make use of the same materials in a greater or less degree of complexity of combination.

In our intercourse with the intellectual world, through books and through association with our fellow-men, we are constantly brought into relation with truths which we desire to appropriate. The manner and form in which we appropriate them will depend upon our own peculiar mental constitution. We are not, or should not be, content to retain them by an act of memory alone, but instinctively desire to make them part of ourselves, just as our material food dare not remain as a foreign body in our digestive organs, but must be assimilated in order to answer the purposes of nutrition. In this appropriation of truth the one will accept it exactly in the form in which it is presented to him, and in that form it will constitute part of his mental content; another will so divide and analyze that it will lose its original form and be scarcely recognizable. In either case, if thoroughly digested and appropriated, it ceases to belong to another and becomes our very own. We do not find it necessary to give the name of our butcher when we tell our weight or strength. We have gone through certain procedures whereby what was his has become ours, and his interest in it has ceased, except in so far as his pride and self-gratulation may find exercise in the thought of having contributed to the growth of such a body. Beecher, when told that some minister was preaching his published sermons, said he was glad, for thereby the circle of his own hearers was enlarged.

Now in drawing from our own mental stores—unless we have all borrowed thoughts put away and labelled, like the articles wrapped in newspaper, lining the shelves in a pawnbroker shop,

waiting to be redeemed—we will put them forth in the same form in which they were appropriated, and of two persons making use of the same borrowed thought, the one who has stored it in its original form will be accused of plagiarism, while the other, who has simply put a different wrapper about it, will be credited with originality. In both cases the plagiarism may be quite unconscious. We dislike that affectation which compels the speaker or writer of some common-place thought, always to add, "as so and so says," lest he be accused of plagiarism.

We are like little Jack Horner, who sat in the corner. We put in our thumb into our mental pie (or "pi" should it be?) and pull out a plum, and say what a great boy am I, while all the time it is a plum that has grown on some one else's tree, but which we have only put into our own pie, and surrounded with our own dough. We don't know it—we are, perhaps, not conscious of having stolen it.

Again, there are cases where the same mental product may appear independently, in two or more individuals, at or near the same time. The laws of thought are such, that in the majority of cases, given two premises as forces, the resultant can be predicted almost with a certainty. Such occurrences are, therefore, not so strange. They have, no doubt, often given rise to false charges of plagiarism which could easily have been refuted had the influence of concomitant circumstances been duly weighed.

The sum of the whole matter is this, that we are all plagiarists, and must in the nature of things be so; that we can be so entirely unconsciously to ourselves, and that even in the claims of priority, a wider investigation might often show that our "section" had already been pre-empted.

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#### VIVAT.

THE tidal wave of commencements has swept over the land, and has deposited, as its flotsam and jetsam on the shores of professional life, hundreds of fresh M.D.'s, who, recovering somewhat from their late experiences, are preparing to go up and possess the land. Fortunately the coast-guard, or better, the immigration inspectors—the examining boards—are on

hand to see that all are possessed of the requisite amount of mental luggage, and that none try to creep in, covering their nakedness with the fig leaf of a diploma. But enter the land the greater number undoubtedly will, and it is well for us old residents to make up our minds how best to receive them. Let it be in the first place with due humility. These young Davids, with the few pebbles gathered by the brook—their ites, their sepses, their anti's—are eager to go up and attack without fear or favor, the Goliaths of disease and death, who have bid defiance so boastfully to us ancient warriors. To us there still seem some things not to be conquered by human means. "Let us be 'umble," as Uriah Heep would say, and let us be willing to acknowledge that perhaps we are mistaken, and that, in these last days, Providence has found it advisable to bestow upon these neophytes extraordinary wisdom, commensurate with their limitless expectations.

In the second place, let us seek to preserve a spirit of hopefulness. We need not despair. We may hope to retain a few of our older families, and of those who have not absorbed too much of the medical knowledge overflowing in the newspapers.

If we carefully cultivate this spirit of humility and of hopefulness, we will be able to welcome most heartily to our midst these strangers, who in spite of their present bold front will many a time stand in need of the encouragement of fraternal advice. Let us meet them as younger brothers, and at all times support them before a critical public. Let them feel that from our own experience has grown the ability to sympathize truly with them in the trials which cannot fail to occur in the life of a young physician. They belong to our guild now, and without reference to any code—which is not needed by those who are true gentlemen, and which will not bind those who are not—let us do unto them as we would wish others to do unto us.

*In omnibus charitas.*

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#### THE INTERNATIONAL HOMOEOPATHIC CONGRESS.

DR. Richard Hughes, Brighton, England, the permanent secretary, announces that in order to meet an American demand, the time of meeting has been changed from July to August 3d to 8th, 1896.

## THE AMERICAN INSTITUTE OF HOMŒOPATHY.

THE next meeting of the American Institute will convene at Detroit, Michigan, Wednesday, June 17, 1896, at 8. P.M. Being preceded by the sessions of the Materia Medica Conference, the first of which will be held at Detroit, on Tuesday, June 16th, at 8 P.M. to 6 P.M., the second from 8 P.M. to 11 P.M., and the third and final one on Wednesday, June 17, 1896, from 10 A.M. to 1 P.M.

At these three sessions there will be presented and discussed the following topics :

1. Has the Law of Similars ever been unequivocally demonstrated by the deduction from general practice, and do we not require its more formal proof by inductive experimental research ?

Essayist, Conrad Wesselhoeft, M.D., Boston, Mass. Discussions by C. W. Butler, M.D., Montclair, N. J. Martin Deschere, M.D., New York. Charles S. Mack, M.D., Chicago, and Charles Mohr, M.D., Philadelphia.

2. In what particulars has the proving of drugs deviated from the rules laid down by Hahnemann in the *Organon*, and in what particulars do Hahnemann's rules and directions for proving drugs differ from, or fall short of, those required by the methods and precautions of modern scientific research ?

Introductory Remarks, T. F. Allen, M.D., N. Y. Essayist, Eldridge C. Price, M.D., Baltimore. Discussions by M. W. Van Denburg, Fort Edward, N. Y.; E. H. Porter, M.D., New York, Conrad Wesselhoeft, M.D., Boston, and George Royal, M.D., Des Moines, Iowa.

3. In the search for the *similimum* shall we endorse Section 8 of the *Organon*, which says that the totality of the symptoms must be the sole indication to direct us in the choice of a remedy ?

Essayist, William Boericke, M.D., San Francisco. Discussions by H. C. Allen, M.D., Chicago, W. J. Hawkes, M.D., Chicago, J. O. Buck, M.D., Cincinnati, O., and L. C. McElwee, M.D., St. Louis, Mo.

The time limit for the above essays and the discussions

thereon, has been fixed as follows : Essays not to exceed thirty minutes; discussions must be limited to fifteen minutes. The essayist is to have an additional fifteen minutes in which he may comment on the matter presented in the discussions.

The balance of the time of each session will be occupied in general discussions of five minutes' duration each.

An unusually large number, more than fifty, have already notified the secretary of their desire to attend and to discuss these subjects. The time has been allotted in the order the requests have been made. This conference will unquestionably be a great success and every one should be on hand for its meetings.

The fifty-second session of the American Institute of Homœopathy will be opened on Wednesday afternoon at 3 P.M., June 17, 1896, and in addition to the regular scientific work, the Centennial Jubilee of the promulgation of homœopathy will be presented in fitting style by a celebration of a public character, to be held in connection with the meeting of the American Institute, at which an address on the character, discoveries and labors of Hahnemann will be delivered by President Dudley—this taking the place of the usual presidential address, and to be known as "The Hahnemann Oration." The celebration is also to include three centennial addresses on the "Law of Similars," to be delivered before the Institute in general session, the addresses being as follows :

1. "The Logical Basis of the Law of Similars. Does it Command Itself to our Reason?" By Dr. Richard N. Foster, Chicago.

2. "The Experimental Demonstration of the Law of Similars. Can its Existence and Operation be Proved?" By Dr. M. W. Van Denburg, Fort Edward, N. Y.

3. "The Clinical Efficacy and Superiority of the Law of Similars. Is it a Reliable Guide in the Practice of Medicine?" By Dr. John Preston Sutherland, Boston.

The character and scope of these addresses added to the work of the regular scientific sections, indicate that the meeting of 1896 will be the most important one ever held by any organization interested in rational therapeutics and scientific medicine. Such original, impartial and searching inquiry calls for and will receive the best work, thought, and experience of the profession.

Finally, every member of the Institute should be on hand to particularly emphasize to the citizens of the State of Michigan the completeness and unanimity of the endorsement of the American Institute of Homœopathy of the position taken by the homœopathic physicians in relation to the homœopathic school at Ann Arbor.

The Institute emphatically endorses the position of the vast body of homœopathic physicians of Michigan, led by Prof. D. A. MacLachlan, First Vice-President of the Institute, a man of large attainments and of splendid efficiency, who, by the sacrifice of his financial success, his personal advancement and his physical comfort, for the rescue of the Ann Arbor school from the strangling grasp of a Board of Regents bent on its destruction, has proved himself to be a leader of the heroic mould.

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**ANTHRAX DEVELOPING AS PURPURA HEMORRHAGICA.**—Jaworski and Nencki, recently observed a governess of thirty-six years who after visiting a relative, a butcher, noticed on her return journey a small abscess of the knee which opened spontaneously and refused to heal. Five days before she was seen, she experienced a general feeling of being ill with chills and fever in the evening. The next day she noticed fleeting pains in her joints and purpuric patches appeared on her hands. Her former general health had been good. Her skin was moist and cold; her eyelids of a blackish violet color, her conjunctivæ were detached by bloody vesicles and her whole body was covered with purpuric patches of different shapes and dimensions, varying in color from red to violet and not disappearing on pressure. On the internal side of the left knee there was a superficial round and livid ulcer which was but little sensitive. Her breath was cold, of a cadaverous odor, her abdomen distended with tenderness in the hypogastrium and epigastrium; her stools were bloody and she also had a flow of blood from the uterus. The urine was scanty and thick, containing albumin, blood and casts. The next day she died. The necropsy showed rapid decomposition, numerous ecchymoses on the serous membranes; the spleen was swollen and softened; the liver slightly hypertrophied and of a grayish-green color. The kidneys presented the appearances of acute nephritis, with extravasation of blood beneath the capsule. There were also ecchymoses into the mucous membrane of the stomach and intestines, particularly that of the small intestine. Examination of her blood during life revealed the presence of the anthrax bacillus; this was also confirmed by the necropsy and inoculations in animals. The clinical picture resembles that of the gastro-intestinal form of anthrax which is usually associated with purpura hemorrhagica, Werlhoff's disease. It is doubtful if infection took place through the abscess on the knee.—*Przeglad Chirurgiczny.*

**SUTURE OF MUCOUS MEMBRANES.**—Padres in suturing the mucous membranes advises a continuous suture, with both ends buried and the suture passing through the lowermost layers of the mucous membrane and the submucous tissue. Both ends must be in the depth of the wound and before taking the last stitch it is well to draw the suture tight in order to bring the edges of the wound together. He usually employs catgut but if a certain amount of tension is required to keep the parts together then silk is best used. The suture will be absorbed and a linear, movable and imperceptible scar will follow. Silk usually gives rise to a rigid cicatrix so it is best to insert the first and last stitches a centimetre from the wound. The cause of faulty union of mucous surfaces is in the secretion gaining entrance into the wound through the stitch holes.—*Rivista Clinica E. Terapeutica.*

## GLEANINGS.

## GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D., AND FRANK H. PRITCHARD, M.D.

**TUBERCULOSIS OF THE KIDNEY AND ITS DIAGNOSIS.**—Professor Jacquot has found this to be a rare disease, appearing chiefly in males from the twentieth to the fortieth years. Though both organs may be affected when there is but one disease, it is usually the right. At the beginning the symptoms are rare, though haematuria, yet rare may be noticed. Pain is an important and valuable significant sign, radiating spontaneously, from the flank into the bladder and associated with dysuria, tenesmus and a constant desire to urinate; the pain may even simulate an attack of renal colic. The urine contains both blood and pus, the former, in cases only observable under the microscope. Collected in a glass the urine separates into two layers; an upper of liquid and a lower of pus. The distinguishing points of tubercular nephritis from other forms of pyuria are: the presence of a tubercular focus in other portions of the body, the acid reaction of the urine, while in the other varieties it is alkaline, the non-homogeneous sediment of the urine, which contains beside pus more or less voluminous flocculi, insoluble in acids and by heat, and finally the presence of the bacilli; this latter sign is the least constant of all, though the flocculi contain them. It may be complicated by hydro- or pyo-nephrosis. The prognosis varies according as the lesion is single or double. The course of the disease is sometimes peculiar. In some cases there are subacute exacerbations of the renal symptoms, with moderate pain and haematuria, then all symptoms disappear until the next attack. As seen the course is insidious. If an individual present signs of repeated congestion of the kidneys, one should first eliminate tubercle.—*Rivista Clinica E Terapeutica*, No. 12, 1895.—[Dr. Routier (*La Semaine Médicale*, August, 1895, abstr. in *HAHNEMANNIAN MONTHLY*, August, 1895), has reported a case where profuse haematuria was the first symptom of renal tuberculosis in a young woman of twenty-eight years. A malignant growth was diagnosed and the organ removed; only two small tuberculous ulcerations were found situated on a papilla. Professor William Osler (*The Principles and Practice of Medicine*, New York, 1892), claims that a differentiation from calculous pyelitis is often difficult. Haemorrhage is less frequent in tuberculous form. There may be irregular fever, chills, and loss of weight and strength. Albumin is present. The most characteristic sign is the detection of tubercle bacilli.—Eds.]

**THE SYMPTOMATOLOGY OF PANCREATIC DIABETES.**—Dr. Harley, though admitting that one may have a diseased pancreas without diabetes, states that it is generally recognized to-day to accompany simple atrophy, atrophy of the pancreatic cells and sclerosis of the interstitial tissue, especially in children with a hereditary syphilis and with atrophy of the cells from occlusions of the duct, as from a cancer of the head, of the gland, or a calculus. The symptoms of the disease in man agree with those obtained by experiments on animals. There is thirst, voracious appetite and polyuria, together with sugar in the urine. These symptoms appear suddenly and the course of the disease is usually rapid; nervous prostration sets in early, with great weariness and sudden emaciation. Coma appears and the disease quickly progresses to a fatal termination. Youthful or comparatively young persons are generally attacked. The feces present characteristic alterations; particles of undigested food swim around in an oily fluid which upon cooling stiffens to a nasty yellowish and greasy mass of a stinking odor. The percentage of sugar in the urine is seldom high yet it may attain 7 per cent. or over; it quickly reaches maximum and generally holds at this percentage until shortly before death when it disappears; the quantity of nitrogenous elements in the urine is decidedly increased; acetone is constantly present. In

some cases there are diacetic acid and beta-oxybutyric acids, which nearly always are forerunners of coma.—*Nordisk Magazin for Lazergivenskaben*, No. 12, 1895.—[The experiments of von Mering and Minkowski show that if a very small piece of the gland be left undisturbed or if a portion be sutured into the abdominal walls, glycosuria would not appear. In such cases the employment of either an extract or the fresh glands internally might be of service.—Eds.]

**A CASE OF MALARIA WITH AN IRREGULAR TYPE OF FEVER, INTERMITTENT NEURALGIA AND AN ABNORMALLY SLOW PULSE.**—Dr. Hoche relates an interesting case of a laborer who from time to time presented attacks of intense abdominal pain, located a little to the right of the umbilicus, and radiating about five cms. upwards and eight cms. downwards. These pains were associated with vomiting, intense fever, of an irregular type, and with slowness of the pulse, which contrasted strangely; sixty to seventy beats in a minute with a temperature of 39.4° to 41.9°. Several physicians had treated the patient and had diagnosed a colitis, or an internal strangulation of the intestine. Having learned that he had lived in a malarial region and had formerly suffered from pronounced malarial attacks he regarded this curious symptom-complex as of malarial origin, and administered a good dose of quinine. The symptoms immediately yielded; they had resisted all other treatment. The reporter regards this condition as dependent on a neuralgia of the pneumogastric of malarial origin. This theory would not explain the bradycardia, but the peculiar pain and its localization, the upper portion of the large small intestine innervated by the coeliac plexus, which besides receiving fibres from the great sympathetic contains sensory fibres from the pneumogastric.—*La Semaine Medicale*, No. 2, 1896.

**A STUDY OF THE PATHOGENIC ACTION OF THE SALTS OF ZINC.**—Dr. L. Maraldì from a series of experiments on animals in the experimental laboratory of Prof. M. Semmola, of Naples, Italy, with regard to the action of zinc concludes as follows :

1. Zinc has a toxic action whose mechanism is not yet well understood.
2. It acts chiefly upon the blood, producing a rapid and intense dissolution of the red corpuscles; yet no haematuria is seen to follow. The spectrum of oxyhaemoglobin is not changed.
3. There is haemoglobinuria, with albuminuria and glycosuria. The albuminuria at first is dependent upon the blood changes, and later on the renal alterations. The glycosuria is probably due to conspicuous pancreatic lesions.
4. Zinc diminishes the motility to complete paralysis from direct action on the muscular fibre, or on the intramuscular terminations of the motor nerves. It obtunds sensibility to pain to entire analgesia.
5. It does not attack the spinal cord nor the reflex centres.
6. It depresses the heart beat function, reducing the number of beats, and weakening cardiac energy in batrachians, while in mammalia it increases the pulse-rate and weakens the systole. It arrests the heart in diastole, after cessation of respiration. It lowers intra-vascular pressure and produces vascular dilatation. This is chiefly due to dilatation of the vessels themselves from direct action of the drug upon the vessel walls 'paralysis'.
7. In large doses zinc is hypnotic. Death takes place from arrest of cardiac paralysis, preceded by that of respiration.—*Il Progresso Medico*, Nos. 8 and 9, 1895.

**DUBOISINE IN THE MORPHINE HABIT.**—Prof. C. Bernabei, of Sienna, Italy, in a case of morphine habit where all other means had failed, obtained a cure in a man who suffered from great weakness and emaciation, anorexia, obstinate constipation, dysuria, and brachycardia, as well as unilateral ephidrosis on the face and insomnia in consequence of the habit, with the hypodermic use of duboisine; he injected from one-quarter to one-half a mgm. a day. In eight hours he was able to sleep; the other symptoms gradually disappeared, the morphine was decreased in dose, and in three months he was able to leave it off as well as the duboisine.—*La Semaine Medicale*, No. 2, 1896.

**ACUTE NEPHRITIS AFTER APPLICATION OF A CANTHARIDAL BLISTER TO THE EPIGASTRIUM**—Dr. Huchard, of Paris, reported the case of a young girl who, suffering from cardialgia and constipation, but otherwise healthy, five days after application to the epigastrium of a cantharidal blister, six cms in diameter, was seized by violent nephritis and uræmia. She eventually recovered. He called

attention to others, Germain See, Potain, etc., having previously recorded similar cases.—*Hospitalstidende*, No. 14, 1895. [Dr de Cressantigne has communicated two cases of fatal poisoning following the use of blisters. They are said to be especially dangerous in acute febrile diseases. Kober, *Lehrbuch der Intoxikationen*, Stuttgart, 1891, warns against employing too extensive blisters, for they may even be followed by a fatal result. Burt cites Stille to the same effect.—Eds.]

**CHLOROTIC THROMBOSIS.**—Prof Hayem, of Paris, at a recent meeting of the Society of the Hospitals of Paris, recorded the case of a chlorotic patient who had suddenly died of pulmonary embolism. The necropsy revealed extensive thrombi in the right auricle. Two years before she had had a phlegmasia alba dolens. Rendu stated that a few years ago he had observed a similar case. At the next meeting, Guinon said that he had seen three cases of thrombosis of the lower extremities in young and chlorotic girls; one died of pulmonary embolism, the others recovered. He regards this variety of thrombosis as of infectious origin. In the first two cases he could not determine the cause, but both patients presented fever. The one had two months before aborted and still had the sequelæ of a probable gonorrhœic elytritis; besides, she also suffered from incipient phthisis. Therefore, he does not think the chlorosis itself the cause of the thrombosis, but a predisposing factor.—*Hospitalstidende*, No. 17, 1895. [Osler, *Practice of Medicine*, 1892, p. 689, mentions this tendency to thrombosis in the veins in chlorosis; most commonly it is in the femoral, but it may occur in the longitudinal sinus, or it may be multiple. Except in the sinuses the condition is rarely serious. Tuckwell has reported an instance where there was thrombosis of the axillary artery (right) with loss of a thumb and a part of the fingers. Brayton Hall has recently called attention to the importance of this feature in chlorosis. As to fever being necessarily an indication of its infectious origin, that does not consequently follow, for as in all forms of essential anaemia fever is not uncommon. In sinus thrombosis, as a rule, the head symptoms are marked: dulness and stupidity, vomiting, dilation of the pupils, and double-choked disks, headache, and possibly delirium.—Eds.]

**PRIMARY CANCER OF THE LIVER WITH FEVER.**—Dr. Achard reports two cases of primary cancer of the liver with symptoms of intense icterus and also associated with a rare symptom: fever. An aseptic puncture made before death revealed the presence of the staphylococcus albus, which had undoubtedly, as a complicating factor, given rise to the fever.—*La Semaine Médicale*, No. 21, 1895. [Prof. Hanot also has communicated the case of a woman who died of a secondary cancer of the liver, associated with intense icterus and a temperature of 105.5. The blood was found to contain the streptococcus.—*La Semaine Médicale*, No. 17, 1896. Osler also calls attention to this complication. He states that it is present in many cases, being usually continuous fever, ranging from 100 to 102; it may also be intermittent, with rigors. He does not attribute it to suppuration in all cases, but to the cancer itself.—Eds.]

**DIFFERENTIAL DIAGNOSIS OF CHRONIC RHEUMATIC AFFECTIONS AND CHRONIC GOUT.**—Dr. Ernest Reynolds attempts to point out the differences between chronic rheumatism, i.e., chronic rheumatoid arthritis and those following acute rheumatic fever, as it affects particularly the hand and its joints.

In chronic rheumatism the joints are attacked upon both sides and the consequent deformities are symmetric; Dupuytren's contracture and those following trauma are to be excluded of course.

In gout, on the contrary, only a few articulations are affected, the degree to which they are involved is different and asymmetric. Although all the joints of a hand may be affected, the single joints are not all gouty to the same extent and the resultant deformity is unequal. Ulnar flexion of both hands may be noticed both in chronic rheumatism and in gout.—*Hospitalstidende*, No. 13, 1895. [Da Costa, *Medical Diagnosis*, 1881, points out the difference between chronic rheumatism and gout as follows: "In gout, the small joints are chiefly or alone affected; in rheumatism, the large. The gouty inflammation is accompanied by more local pain and redness than the rheumatic, and by œdema, enlargement of the veins, and desquamation of the cuticle, and impinges, at least at first, only one or a few joints, especially the joint of the great toe; while rheumatism attacks the joints of the upper, as well as of the lower extremities. In gout there is a tendency to disease of the kidneys, with moderate febrile disturbance and no profuse

sweats; there is no cardiac involvement as in rheumatism. Gout is more decidedly hereditary than rheumatism; its early attacks are apt to recur with a certain amount of periodicity, and last about a week, therefore a much shorter time than those of rheumatic fevers."—Eds.]

**ANGINA PECTORIS.**—Prof. P. Grocco, of Florence, Italy, would base a diagnosis of angina pectoris on the following three symptoms:

a. A paroxysmal pain coming on in attacks and appearing in the region of the heart, which pain is intense, profound, oppressing, crushing or piercing, and which may radiate into other regions, as those supplied by the left cervico brachial and cervical plexuses;

b. An instinctive desire to remain quiet, motionless, it seeming as if every movement would cost the patient his life;

c. An indescribable sensation of threatened arrest of life, of imminent death. This sensation is often presented by the patient's face and the experienced physician will easily detect it.

These three symptoms are the cardinal triad for the making of a diagnosis. Anything which overloads the heart and brings on an attack is of great diagnostic value, as ascending stairs, running, etc. The pains are generally retro-sternal, yet there are patients who will complain of the pain running forward from the back and constricting the heart. The other two symptoms may vary. Sometimes the seizure may be masked under cardiac asthma, but on analysis the pain will be found characteristic, the patient will remain motionless, the period of greatest asthma will be that of greatest anguish, and at this period the "hand of iron" will be felt to constrict the heart.

An attack of intercostal neuralgia may cover the true disease but here the pain is deep seated, goes to the heart and during the seizure the sufferer remains rigid and seems and feels to be dying; then again the characteristic Valleix points are absent.

A gastralgia in some cases may be diagnosticated from superficial examination, but the pain is diffused towards the heart, if not to the brachial plexus; it appears paroxysmally with characteristic symptoms and independent of the stomach.

Attacks of palpitation with pain may resemble it, but with angina the pain is out of all proportion to the attack. *The mortal anguish from angina pectoris never is due to painful palpitation.*

Tachycardia in some cases may precede the angina, but the danger is decidedly less, and instead of the tendency of the patient to remain quiet, he is restless.

Neurosthenia may be complicated by pseudo anginose states, but the fear of death is associated with a noisiness and lamenting, while the pain is less acute and more diffuse and variable. The co-existence of other nervous symptoms will clear up the diagnosis.

In making a diagnosis it is not necessary to find signs of atheromatosis of the blood-vessels: neuritic symptoms may be present in other parts of the body and the disease be associated with states where neuritis easily develops, as tabes dorsalis, diabetes, etc. It is not requisite to have an increased systole with the attack to make a clear diagnosis. Rheumatism, neuralgia and affections in general of other nerve-areas, may be the provoking causes, and especially those which are closely connected with the cardiac nerves—brachial plexus, cervical or intercostal nerves. Attacks of true angina may alternate with simple cardiodynia; they may follow each other periodically.—*La Settimana Medica*, No. 14, 1896. [John Hunter was a sufferer from this disease. "My life is in the hands of any rascal who chooses to annoy and tease me," he often said. And indeed, after suffering for many years from these seizures, his ungovernable temper brought on one in which he expired. Da Costa directs attention to a similar state, cardiac epilepsy, which may be confounded with angina pectoris. In this rare affection, intense pain in the region of the heart happens in paroxysms. But unconsciousness, however temporary, occurs also and the pain is more apt to follow than to precede the unconsciousness. Yet it may outlast it, and become associated with twitching of the muscles of the face and other spasmoid movements. These, the unconsciousness, and the time in which the pain happens, distinguish the malady from those instances of angina in which, owing to the severity of the pain, the patient passes into a protracted faint.—Eds.]

**A SEVERE FORM OF INTESTINAL COLIC.**—Dr. Fessler, an Austrian military surgeon, has observed, in the course of two and a half months, eight cases of severe

intestinal colic, in soldiers of the same battalion. In all the cases the colic was seated in the region of the navel; it was so intense that it caused repeated attacks of convulsions which were either tetanic or epileptiform, and which lasted about twenty seconds. In four of the cases after the attack the corneal reflex was absent. During the seizure the patients were confused, did not know where they were, laughed and cried without cause, etc. He attributed the colic and the nervous symptoms to poisoning with putrid intestinal gases. He treated his cases with enormous doses of morphine, one-half to two grains hypodermically.—*Berliner Klinische Wochenschrift*, No 15, 1896.

## GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D. AND H. L. NORTHRUP, M.D.

**METALLIC SILVER AND SILVER LACTATE AND CITRATE IN SURGERY.**—In the *Deutsche Medizinal Zeitung*, Crede gives the results of his investigations of silver and some of its salts as antiseptics. He has satisfied himself that metallic silver, when brought into contact with colonies of schizomycetes, kills them without exerting any unfavorable action on the animal tissues. So it may be remarked that the late Dr. Marion Sims's choice of silver wire as a material for sutures was happier than could be realized at the time. Crede says that aseptic wounds coated with silver foil remain aseptic for weeks at a time, and heal better than with any other dressing. Instead of silver foil, he has lately employed a dressing material made by Max Arnold, of Chemnitz, in the fabric of which metallic silver is intimately blended in such a manner as to admit of its being cut or torn into any shape desired. There is also a dressing in the form of a mull containing powdered silver that may with advantage be substituted for iodoform gauze in packing deep wounds.

Numerous experiments have shown that silver forms a lactate with the lactic acid produced in the metabolism of the micro-organisms, and that this compound kills them. Therefore it occurred to Crede to make direct use of silver lactate, instead of silver in the metallic state. This preparation, known by the trade name of *actol* or *aktol*, he thinks fulfills all the requirements of an antiseptic better than any other. He has given as much as fifteen grains of it subcutaneously without the least ill effect; there was only a slight burning pain at the site of the injection, lasting but a few minutes. Silver lactate forms no insoluble compounds with the alkaline secretions of a wound or with tissue juice, as, for example, corrosive sublimate does, but only soluble ones, which gradually permeate the tissues and thus extend their action to some distance from the surface.

Silver citrate, however, seems to be quite as efficient and to be free from some minor disadvantages (not specified) of the lactate. The citrate has the trade name of *irol*. Crede says that it is a perfectly harmless antiseptic and an excellent dusting powder for wounds. In the course of four months he has treated many hundreds of wounds with it, and with never the least untoward effect.

**SIOL IN THE TREATMENT OF TUBERCULOSIS OF BONES.**—Reynier states that, in the presence of limited osseous tuberculosis, just beginning, the surgeon often hesitated to interfere by trephining, as there was no exact information in regard to the limits of the field of operation. Grattage was practiced and continued until a more resisting osseous tissue was met with; the period of time necessary for cicatrization was uncertain; usually it occurred slowly, consequently relapses, fresh abscesses, and persistent fistule were to be feared.

In view of the difficulties attendant upon operations of this nature, Reynier employed a method of dressing which had been introduced by him in 1891. This dressing consisted of salol which was liquified at a temperature of 104° F., and mixed with naphthol, aristol, and iodoform. If, after having trephined the bone and cleansed the tuberculous region, the cavity was filled with the melted salol, the latter would crystallize at 82° F., and obliterate the cavity entirely. In this way, says Reynier, a complete and aseptic occlusion is obtained. Furthermore, union by first intention of the overlying skin might be effected with this method of closure, which was similar to plugging the teeth.

Reynier states that he has operated upon six patients and employed this dressing, with the results that he had obtained a rapid recovery in a few days after the filling of the osseous cavity with this antiseptic mixture, and that immediate union of the skin and the subcutaneous connective tissue had taken place.

**A NEW METHOD OF ANTISEPTIC WOUND TREATMENT.**—Schleich states that if a watery solution of gelatin be dried after exposure to formalin vapor, there results a new chemical body possessing entirely new properties. This preparation in contact with animal tissues results in the breaking up of the absorbable gelatin, lasting for several hours, and a gradual setting free of the formalin. In this way the action of the drug is continued over a considerable period of time. The results of the use of this antiseptic in powder form have been, that in 120 cases of acute purulent processes, 93 of aseptic healing of wounds, 4 complicated fractures, and 2 deep wounds of the scalp, success without exception has been obtained. In all cases of acute suppuration the inflammation has been brought to an end within twenty-four hours, the fractures healed aseptically and without fever, and aseptic operations pursued an uneventful course. In the presence of fresh blood and clean condition of the wound, the powder gave rise to a dry and permanent scab. In recent suppuration without necrosis the process was brought to a standstill within twenty-four hours. Boils, carbuncles, and phlegmons can be limited within the same time if the powder is brought into contact with the tissues.

The process of manufacture is as follows: A pound of dissolved and purified gelatin is brought in contact with 25 drops of a pure solution of formalin. The dried masses are rubbed up or powdered, and preserved dry with the addition of some drops of formalin.—*Therapeut. Monats.*

**A SUGGESTION IN ETHER ADMINISTRATION.**—Ludlow states that when ether is mixed with twice its volume of a bland, light preparation of liquid petroleum and thoroughly nebulized with a suitable atomizer, it is absolutely unirritating, and even with a much smaller proportion of oil is practically so. The oil, by preventing irritation, avoids not only immediate reflex disturbances, but all direct injury to the mucous membrane. A few puffs of the mixture from an atomizer directly into the nostrils before administering ether in the usual way result in the anesthetic being easily taken, without stage of excitement and with practically none of the common annoyances incident to its use. In this way it is hoped that the objectionable features of ether anesthesia, which are to be attributed directly or reflexly to its irritation of the mucous membrane, can be lessened or prevented.—*Philadelphia Polyclinic.*

**CANCER OF THE RECTUM: TREATMENT, OPERATIVE OR PALLIATIVE.**—Allingham says that some authorities appear to hold that all cases of cancer of the rectum demand either excision or colotomy, quite irrespective of many points which require careful attention. Thus, cases sometimes come to one in which excision is requested when colotomy should really be done, or vice versa, or, again, when neither operation is needed.

Allingham then goes on to say that he has seen about 720 cases of this malady, having performed excision 62 times and colotomy 133 times. He has thus been led to make a mental classification of the cases reported according to the various lines of action which should be pursued.

In arriving at this classification the following points must be kept prominently in view: (a) the age of the patient, (b) the position and extent of the growth, and (c) the nature of the symptoms, viz., obstruction of the bowels, constant diarrhoea, hemorrhage, or pain. By this classification, cases of cancer of the rectum may be divided into those which are fitted for excision, for colotomy, or for palliative treatment.

The question of age is a most important matter. If the patient's age does not exceed 45 years, very little is to be gained by excision, even if the growth is within a reasonable distance from the anus. It appears that after excision in such cases, the malignant disease returns often before the wounds resulting from the operation have healed. Again, colotomy seems to prolong the patient's life for an extremely short period.

In patients between 45 and 60 years, the prognosis, as regards excision, is more favorable, and this operation should be attempted when the growth is well to the lower part of the rectum. In this class, colotomy for disease high up the rectum should be performed only when the symptoms above enumerated are well marked, and when palliative treatment has failed to afford relief.

For patients above 60 years, excision is extremely favorable in suitable cases, and should always be attempted when there is a fair chance for a thorough removal of the growth. The remarks with regard to colotomy are the same as those applied to patients between 45 and 60 years.

Thus it will be seen from the above classification that the older the patient becomes, the less rapidly does the malignant disease grow and the less likely is it to recur.

There are some who advise colotomy in nearly all cases of cancer of the rectum which come before them, imagining that by diverting the feces they may succeed in arresting the rapidity of the growth. This Allingham does not believe to be in the slightest degree the case.

One last remark must be made. In cases of cancer high up the bowel it may be necessary to starve the patient, or at least subject him to what is practically starvation, in order to keep him comfortable. In consequence of this starving the patient may become exceedingly emaciated, and may, perhaps, express the opinion that the treatment is worse than the disease. In such a case Allingham would not hesitate to perform colotomy, so that the local symptoms, viz., obstruction, may be obviated. When this has been done the patient can eat and drink as he chooses, and, as a rule, rapidly puts on flesh, and recovers his general health for a time, that is to say, until the malignant disease begins to attack other important organs.—*London Lancet*.

**HEMIPLEGIA AFTER A BLOW UPON THE HEAD—OPERATION—RECOVERY.**—Frey reports a case from Mosetig's service where a man receiving a blow on the head from a cramp iron, in a brawl, fell to the ground unconscious; no signs of concussion of the brain or vomiting. On coming to himself he was completely hemiplegic on his left side, and the left corner of the mouth was flaccid and immovable; complete amaurosis of the corresponding eye of two days' duration. After nine days he entered the hospital. A small and purulent wound was found penetrating through the middle portion of the right parietal bone into the brain. Trepanation was done, and a piece of bone six by four centimeters square was chiselled out. The dura mater was found punctured, the inner table splintered, and quite an extensive blood clot exposed under the dura mater; the cortex seen to be punctured and contused. The clot was removed, the wound irrigated with a solution of salicylic acid, and iodoform dusted in. The dural wound could not be completely closed; suture of the external wound and drainage. Healing by first intention followed except at the point of drainage. Already five days after the operation he could move his left big toe, in several days the foot, and in four weeks he could walk about. The upper extremity recovered less rapidly. The facial paralysis persisted somewhat though he now can move his lips and whistle. The place of drainage healed slowly. As a granulating button formed here it was touched five weeks after the operation with the nitrate of silver stick. Three hours later he had an epileptic attack, beginning with formication in the little and ring fingers and extending up to the elbow-joint. Then succeeded loss of consciousness, clonic spasms of the upper arm and muscles of the left shoulder, tonic and clonic spasms of neck and chest muscles, tonic spasms of the left thigh, the left leg and foot. When the applications were repeated several days later the convulsions recurred; in all, at four different times. As they were ascribed to irritation of the cicatrix the caustic was discontinued and since then, six weeks, he has had no further attacks. The wound has healed completely, even the wound of the bone has been filled in by a new growth of osseous tissue and the patient feels entirely well.—*Wiener Medizinische Presse*.

**TO INCREASE THE ANALGESIC EFFECT OF COCAINE IN OPERATING FOR HYDROCELE.**—Manget has found that a 2 per cent. solution of cocaine mixed with the fresh serum of hydrocele forms an insoluble precipitate of the fibro-albuminate of cocaine, which is insoluble in a solution of iodine. Hence, to obtain the full analgesic effect one should first irrigate the sac of the hydrocele, after puncture, with a 5 per cent. solution of sodium chloride.—*La Semaine Médicale*.

**ABDOMINAL WOUND WITH ENORMOUS PROLAPSE OF INTESTINES—RECOVERY.**—Kleinberg records the case of a peasant woman of forty-six years who was attacked by a boar and received a lacerated wound of the abdomen from its tusk. A portion of her intestines prolapsed, which she replaced, and dragged herself, half fainting, to the next village. In the meantime, larger masses of intestines had pushed themselves out, which neither she nor the other peasants were able to re-

place. Seven hours after the injury the writer found the patient collapsed, and nearly the whole small intestine lying upon her abdomen. The coils were distended, injected, and dark red in color, but the serous coat still glistened.

On account of the condition of the patient and the lack of proper assistance he did not attempt to anæsthetize her. After antisепtic precautions and under the most unfavorable conditions, in a filthy peasant hut, with faulty light, he attempted to replace the intestines. The wound, situated to the right of and below the umbilicus, had to be enlarged before this was accomplished. The intestines were first washed with a 4 per cent. solution of boric acid in well water which had been boiled and filtered through cotton. A recovery followed, complicated only by a small abscess of the abdominal wall.—*St. Petersburger Medicinische Wochenschrift.*

## GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D.

**ASEPSIS AND ANTISEPSIS IN OBSTETRICS, ESPECIALLY AS SHOWN IN THE CLINIC OF GUSTAV BRAUN IN VIENNA.**—(R. Braun v. Fernwald.) After the consideration of the methods employed there and a comparison with other clinics, he draws the following conclusions :

1. Asepsis and antisepsis should be combined in obstetrical practice.
2. In the last months of pregnancy vaginal irrigations should not be employed except when pathological secretions are present.
3. Internal examinations are to be avoided so far as possible during labor, and greater attention should be given to the external examination.
4. Vaginal irrigations should be omitted as a rule in normal labor, but are to be used if there is a thick, purulent leucorrhœa, if there is a rise of temperature, before an internal examination, if the asepsis of the hand is uncertain, and especially if frequent examinations are made. Lysol in a 1 per cent. solution recommended for the irrigating fluid. Corrosive sublimate is to be avoided.
5. The vagina should be thoroughly irrigated with lysol before any operation.
6. An intra-uterine douche must be used after an operation in which the hand of the operator has passed into the uterine cavity. Intra-uterine irrigation must be used after labor when the amniotic fluid is thick, discolored or offensive; after the birth of a macerated decaying fetus, also if there is a rise of temperature after a labor which has not been aseptically conducted.
7. No vaginal douche should be used in a normal puerperal convalescence.
8. Vaginal irrigations in the puerperal period are indicated by offensive lochia and a rise of temperature.
9. The antisепtic treatment of puerperal diseases must be undertaken methodically; not every rise of temperature needs an intra-uterine douche; the ulcers which may be present in the vagina or cervix need treatment first.
10. All intra-uterine douches should be given with the aid of sight, i.e., with a speculum or retractor.
11. Permanganate of potash, a wine-red solution, is recommended for the intra-uterine douche twice in twenty-four hours.
12. The introduction of an iodoform pencil into the uterine cavity after irrigation is unnecessary, no tampon should be used in the vagina; in severe cases the uterine cavity can be wiped out with the tincture of iodine.
13. The uterine cavity can be curetted with a broad curette if there has been no improvement after two successive intra irrigations, provided there are no signs of peritoneal irritation. The intra-uterine douche must be used before and after the curetting. The uterus must not be curetted more than once; it is absolutely contra-indicated. —*Centralblatt für Gynäkologie*, No. 15, 1896.

**THE TREATMENT OF VOMITING OF PREGNANCY BY TAMPONING THE CERVICAL CANAL WITH GALZE.**—(F. A. Kehrer). The patient suffered severely from the beginning of pregnancy with nausea and vomiting, and from peculiar convulsive attacks similar to hysteria, though the diagnosis is not mentioned. All the

organs of the body were healthy. The treatment of the vomiting was, first, bromide of soda, 1.0 g. three times a day for a week without success; next, tincture of nux vomica, fifteen drops four times a day for three days, then a solution of muriate of cocaine 0.15 : 1.60 g., one teaspoonful once in half an hour for several days. This remedy was also unsuccessful. The cervix was also bathed with a 10 per cent. solution of nitrate of silver with no benefit. Copeman's dilatation of the cervix with the finger was not tried, as the os was very small. Amyl hydrate in doses of 2 to 2½ g. was given for sleep, and later trional 1.5 g. with success. Tablets of rhubarb root and an infusion of senna were used as necessary for constipation. The patient became very much reduced, and as the treatment was unsuccessful, the induction of abortion was decided upon. The cervical canal was packed with iodoform gauze to induce abortion, but the vomiting began to improve at once, and ceased with the introduction of the second tampon. Slight pains began, but as the patient was better, no further attempt was made to induce labor. There was no return of the nausea for six weeks, and the patient was able to leave her bed. The vomiting then began again, and was relieved by a gauze tampon in the cervix for twenty-four hours. A month later the vomiting returned, and was relieved in like manner again. In another month, in the eighth month of her pregnancy, vomiting once more returned, and was accompanied by so much prostration and weakness it was necessary to induce premature labor. Glycerine gauze was introduced into the uterine cavity and renewed the following day. This excited some severe pains, and the cervix dilated to the size of a dollar. The cervix was found to be very hard, dense, and resistant, so that incision of it was necessary, after which dilatation progressed and a live child was born, which has continued to thrive.—*Centralblatt für Gynäkologie*, No. 15, 1896.

**THE TREATMENT OF RETRO-UTERINE DEVIATIONS OF THE UTERUS BY SHORTENING OF THE UTERO-SACRAL LIGAMENTS AND THE ROUND LIGAMENTS THROUGH THE VAGINA.** (Wertheim and Mendi.)—This operation is recommended for retro-deviations of the uterus and relaxation of the vagina. Silk or silkworm gut is recommended for sutures. The vesico-uterine fold is freely opened and the uterus dislocated down through the opening so low that its posterior surface is plainly visible as well as the peritoneal folds passing from each side of the rectum to the uterus. Any perimetral adhesions which may be present are separated. The slack in the utero-sacral ligaments is ascertained by traction on them, with silk guy ropes or forceps. The slack portion of the ligament is gathered together or sutured by rather deep stitches under the serous membrane in plain sight. The sutures when tied draw the cervix up and back in the pelvis. The round ligaments are then brought down and shortened in the vagina with the aid of silk guy ropes. This brings the fundus of the uterus forwards, while the former operation carries the cervix high up and posterior in the pelvis. Three cases have been operated on with remarkable success by this method.—*Centralblatt für Gynäkologie*, No. 18, 1896.

**TRANSACTIONS OF THE OBSTETRICAL AND GYNÄCOLOGICAL SOCIETY OF BERLIN.**—The Treatment of Pruritus Vulva. Ruge is of the opinion that this disease is almost always due to a local cause, either chronic or bacterial irritation, and that even the most severe cases will be cured by very thorough cleansing. In recent gonorrhœa causing the pruritis, the genitals must be very thoroughly rubbed with plenty of soap and water to free the genitals from the germs. Martin recommended similar treatment and also shaving the pubes and applying the flowers of sulphur. Flaischlen confirmed the statements of Ruge concerning the soaping and cleansing of the external genitals and praised the benefit to be obtained from strong solutions of nitrate of silver (2½ per cent.). Glockner uses a 1 per cent. solution of sulphate of zinc, and follows it with a 10 per cent. aristol ointment. Gottschalk recommends a 10 per cent. thyme oil ointment, and also one of menthol and cocaine. Olshausen drew attention to the fact that in some cases the pruritus was due to diabetes.—*Centralblatt für Gynäkologie*, No. 18, 1896.

**THE TREATMENT OF OCCIPITO-POSTERIOR POSITIONS OF THE HEAD BY MANUAL REPOSITION WITH THE HAND.** (Jungmann.)—After the patient is etherized and catheterized, she is placed on the side corresponding to the chin of the child, the operator introduces the half or whole hand as may be necessary in the vagina and two fingers in the uterine cavity. An assistant presses the child's shoulder upwards and backwards from above and the breech down, while the operator

places the fingers in the uterine cavity on the upper jaw of the child and with the other hand presses the occiput down in the pelvis. By this manipulation he presses up the upper jaw, then the forehead, the large fontanelle and finally seizes the occiput and draws it down into the pelvis, if the manipulations have not been already successful. It is especially important to first press up the upper jaw so as to dislodge the face and make easy the flexion of the head on its transverse axis. Keep the fingers away from the lower jaw, as manipulations here are apt to cause premature movements of swallowing. After the head is brought down it must be retained in position by firm pressure till strong pains come to hold it in place.—*Archiv für Gynäkologie*, Bd. LI., H. 2, 1893.

**A NEW METHOD OF VAGINAL FIXATION OF THE UTERUS**—From Prof. Schauta's Clinic in Vienna—E. Wertheim.—Complications of pregnancy and labor arise in any antefixation of the uterus if the fixation interferes with the free growth and development of the gravid uterus. This is true of all anterior fixations whether ventral or vaginal. This can be avoided by vaginal fixation of the uterus by the round ligaments in the following manner:

1. Opening the plica vesico-uterina freely and with as broad and transverse an opening as possible.

2. Anteverting the uterus, making the round ligaments visible and drawing them down on each side. After making the anterior incision in the vesico-uterine fold the cervix is pushed back in the hollow of the sacrum to throw the fundus forward. The finger is then introduced into the peritoneal cavity through the incision up over the fundus uteri and out over the broad ligament so as to hook down the round ligament of either side into the incision without the use of any tenaculum or instrument to bruise or wound the perimetrium. It is not necessary to bring the uterus in the vagina to make the round ligaments visible. A ligament can be brought down by the finger and held by a loop of ligature which is not tied but held by a pair of forceps.

3. Fixation of the ligaments and closure of the wound. The sewing of the round ligaments to the peritoneal margins of the wound is not enough to prevent recurrence, unless the corners of the points of fixation are brought down and stitched to the vaginal incision. If a more thorough fixation is desired the fixation suture should pass through the margin of the vaginal wound and then through the round ligament so as to bring it down to the vagina, at the end or corner of the transverse incision, where it is tied. The uterus lies in anteflexion after this operation quite as good as if the uterus itself was fixed. Prof. Schanta has operated four times successfully in this manner, but sufficient time has not passed to judge of permanent results, as pregnancy and labor are the real tests of all such operations. The operation might well be termed a vaginal Alexander-Adams operation. Dr. Bode, of Dresden, claims priority of this operation.—*Centralblatt für Gynäkologie*, Nos. 10 and 13, 1896.

**THE RESULTS OF 476 VAGINAL HYSTERECTOMIES**—Richelot.—Richelot, at the end of 1893, had performed 274 vaginal hysterectomies, 84 of which were for carcinoma of the uterus, with 3 deaths; 61 for purulent diseases of the appendages, with 5 deaths; 12 for other diseases of the appendages, with 5 deaths; and 43 cases of uterine myomas, with 1 death. From the end of 1893 to August 1, 1895, he has performed 22 more hysterectomies: 14 for carcinoma of the uterus, with 3 deaths; 66 for purulent disease of the appendages, with 3 deaths; 89 for other diseases of the appendages, with 2 deaths; and 31 for uterine myomas, with 2 deaths. The last 202 operations show a mortality of 4.95 per cent.; deducting the cases of cancer, 3.72 per cent. The mortality of operations for purulent diseases of the tubes was 4.54 per cent., and, of other diseases of the tubes, 2.24 per cent.—*Mercredi Méd.*, No. 47, 1895.

**THE TREATMENT OF THE STUMP AFTER SUPRAVAGINAL HYSTERECTOMY**—Runge.—He formerly disinfected the cervical canal, but now limits himself to disinfestation of the vagina and packing it with iodiform gauze. He amputates the uterus after Shroeder's method. The stump is cut as small as possible and the cervical canal rimmed out. The flaps are then united by *etage* sutures, which draw the stump closely together; no attempt is made to unite the peritoneum over the stump. If there is any oozing, the sides of the stump are ligated. He reports twenty-seven operations performed in this manner, with twenty-six uneventful recoveries. One case died from pneumonia.—*Centralblatt für Gynäkologie*, No. 49, 1895.

## OPHTHALMOLOGY, OTOLGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

**DESCENDING OPTIC NEURITIS CONSEQUENT UPON NASAL TREATMENT.**—Temporary amblyopia and narrowing of the field of vision, apparently reflex or combined with hyperemia of the eyeball, following the application of the galvanocautery to the nasal mucous membrane, have been reported by a number of observers. Alt reports a case of a somewhat different and more serious nature.

A man, aged thirty-eight years, had been treated for nasal catarrh and narrowing of the left nasal passage by means of different applications and the galvanocautery. He noticed the left eye did not see as well as usual, and mentioned it to his physician. Treatment was persisted in, and two days later he awoke to find the eye blind. When seen that day by Alt there was doubtful perception of light, the pupil was dilated and scarcely reacting. The margins of the optic papilla were almost invisible, the retinal veins were hyperemic, the arteries thin. Tension was normal.

The nasal treatment was stopped. On the third day the patient counted fingers at one foot, and on the sixth day at five feet, with considerable increase of the field. A few days later injections of strychnine were commenced, and by the eighteenth day he had regained nearly perfect vision, the field being still somewhat narrowed, except upward and outward. The arteries were still thin and papilla almost white.

Afterward Alt learned that the patient had had syphilis, and he thinks that to this was in some measure due the severity of the attack; but that it could only be accused of being an indirect cause of the trouble by rendering the patient more vulnerable, since only the eye on the affected side was involved, and it improved promptly on mere cessation of the nasal treatment.—*American Journal of Ophthalmology*.

**TREATMENT OF OCULAR SYPHILIS BY MERCURY, POTASSIUM IODIDE, AND PILOCARPINE.**—Burnham reports greatly increased efficiency in the treatment of syphilis of the eye by the addition of pilocarpine to the ordinary mixed treatment. The pilocarpine was given hypodermically in doses of one-eighth to one-fourth grain daily, unless its administration gave rise to nausea, headaches, or oppression over the heart, when it was stopped for a day or two. This was continued for two or three weeks, then intermittent, the mercury and potassium iodide being continued through the interval.—*Archives of Ophthalmology*.

**SCOPOLAMIN HYDROCHLORATE AS A CYCLOPEGIC.**—Murrell employs this drug for the purpose of paralyzing the accommodation for the measurement of ametropia, and is confident that so far it is the best cyclopegic that we have. He has employed it in fifty-seven cases in a solution of 1:1000, making two instillations at an interval of fifteen minutes, and has never had any evidence of want of total suspension of the accommodation at the end of an hour from the first application. From such a use of the drug he has seen no systemic poisoning or local irritation. The accommodation is regained sufficiently to read in about seventy two hours.—*Annals of Ophthalmology and Otology*.

**FORMALIN IN OPHTHALMIC PRACTICE.**—Burnett calls attention to the therapeutic value of this drug in ophthalmic medicine and surgery. It is a germicide of great power, it has little, if any, toxic properties, and it has the power of diffusing itself rapidly through the tissues. The latter quality gives it a great advantage over mercuric chloride, which by its coagulative action greatly limits its sphere of efficiency.

Burnett has obtained excellent results from its use in infecting ulcers of the cornea and purulent conjunctivitis. Corneal ulcers may be touched with a solution of 1 to 200 or 1 to 500 every day. For general use as an antiseptic collyrium a strength of 1 to 1000 or 1 to 200 may be employed, although the stronger of these sometimes causes a slight burning sensation. For the disinfection of instruments and keeping them aseptic, it has the advantage of not dulling the edges of knives.—*Ophthalmic Record*.

**FOREIGN BODY IN THE EAR.**—Böke records a case of fatal meningitis set up by unskillful efforts at removal of a foreign substance from the ear of a child, three and one-half years old.

If the average medical man would only remember that a simple substance which a child can slip into the external ear could be syringed out by anybody, how much trouble would be saved. Gentle measures always succeed, and rough ones never, while the latter always do harm and often cause death.—*Archiv. f. Ohrenk.*

**A BURN OF THE ENTIRE SURFACE OF THE CORNEA FOLLOWED BY RECOVERY.**—Fleming reports the case of a man 38 years old who had been at work in an iron foundry, where he tried to drive a red-hot rivet into a boiler with a sledge hammer. The rivet slipped, and with great force struck him in the left eye. On examination, a slight cut was found through the skin of the upper eyelid the skin was seared, the eyelashes were burned off, and the lids were much swollen and extremely painful. Great photophobia and lachrymation were present, which made it very difficult to separate the lids, but after a few drops of a solution of cocaine had been inserted, and hot fomentations used, the lids were opened. The whole of the eyeball was covered with small scales of iron, which adhered tenaciously to the surface, but were finally removed with pledgets of absorbent cotton and a probe, aided by a most thorough flushing of sterilized water. The entire corneal surface was covered with a grayish, thick exudation, resembling very much that seen in a case of diphtheritic conjunctivitis. The conjunctiva, although intensely injected and swollen, seemed to be intact. The appearance of the cornea was very startling, and the prognosis seemed very grave, as it looked as if not only the epithelial layer, but much of the deeper tissue as well, had been destroyed. The anterior chamber could not be made out at all through the opaque covering, and vision was reduced to light perception only. After the eye had been cleansed as thoroughly as possible, and a solution of atropine and cocaine (four grains of each to an ounce of water) had been applied copiously, a pressure bandage was applied. The patient was then sent home and instructed to instill a few drops of the same solution into the eye every few hours, and to return on the following day. When seen the next afternoon, he reported himself as feeling very comfortable, and on removing the bandage and inspecting the eye, Fleming says he was greatly surprised to find a perfectly transparent cornea, clear as crystal, and as smooth as the most polished mirror. Except for considerable injection of the conjunctiva, the patient was almost as well as ever and went on to an uneventful recovery.

The object of all treatment of burns of the cornea, says the author, is to allay pain and irritation as much as possible, while nature heals the injury. No known method of treatment will prevent the burned tissues from sloughing away. All irritants must be excluded as harmful. In the combination of atropine and cocaine, indicated above, we have the best possible application for all kinds of burns of the cornea. The cocaine kills the pain, while the atropine, by its direct and almost specific action on the cornea, prevents inflammation and assists nature in the healing process. Both are powerful anodynes, and their combination gives us a most admirable treatment for this class of injuries.

A not uncommon form of injury and a very dangerous one, says Fleming, is that from lime splashed into the eye. Quicklime acts as a powerful caustic, and often causes complete blindness by destroying the vitality of the cornea and converting it into a hopelessly opaque substance. The gravity of burns of any kind, especially caustics, is not appreciated by inexperienced observers, who are, consequently, likely to make serious errors of prognosis. Even when the conjunctiva only is affected, the eye may be seriously disabled by the growing together of the lid and the ball. The lime or other caustic should, of course, be thoroughly and instantly washed out with water, and any that may remain should be neutralized by bathing the eye with vinegar and water in the proportion of a teaspoonful of vinegar to a glass of water, or rendered inert by sweet oil. The latter is equally efficient and more soothing. In case of injury by acids, one part of lime-water to three of water may be used, or the eye may be freely bathed with milk.

Cases of total leucoma following burns, says the author, have been seen, in which the cornea appeared thoroughly clear for a whole week after the injury, and in the case of a physician who had both eyes injured by strong liquor ammonia, the left eye was thought by his medical attendant to be in a satisfactory condition five days after the injury, when in reality the seemingly pellucid cornea was represented only by Descemet's membrane, the entire corneal substance having been destroyed and exfoliated.—*Journal of Eye, Ear and Throat Diseases.*

**MONTHLY RETROSPECT  
OF HOMŒOPATHIC MATERIA MEDICA AND  
THERAPEUTICS.**

CONDUCTED BY

CLARENCE BARTLETT, M.D.,  
FRANK H. PRITCHARD, M.D., AND F. MORTIMER LAWRENCE, M.D.

**THE FERRUM AND MANGANUM COUGH RELIEVED BY LYING DOWN.**—Dr. J. R. P. Lambert recalls that in the *Homœopathic World* for February, 1895, a case was quoted from the *Medical Century* of a cough relieved by lying down, which one dose of *ferrum met.* 30 cured. To this case Dr. Clarke added this note. “Compare *manganum*, the metallic congener of *ferrum*, which also has ‘cough ceasing on lying down.’” Since reading this Dr. Lambert has had occasion to verify this symptom with each of these remedies, and a short account of the two cases is of interest.

**CASE I.**—Mrs C. complained of having had a bad cold for two weeks. It began with a sore throat, and left a very troublesome cough, described as loose and rattling, the rattling being felt low down in the chest. It was accompanied by a splitting headache, and only troubled her during the day, ceasing on lying down at night. There was no expectoration, and physical examination revealed nothing except pulse 92 and temperature normal. Of *ferrum phos.*, 2x, a grain or two was placed in a tumbler of water, and dessertspoonful doses ordered. The action was very prompt, and in twelve hours she considered herself cured.

**CASE II.**—W. I., aged 51, an out-patient at the London Homœopathic Hospital under Dr. MacNish, came under treatment on October 2<sup>nd</sup>, 1897, complaining of having had a cold for a week. His symptoms were, “cough worse at night, keeping him awake, with copious expectoration of white, tenacious sputum, also heaviness in the chest, and aching in the left lumbar region.” He had had a similar attack four years ago. On examination Dr. MacNish noted prolonged expiration all over the chest, with rales at the end of expiration. For this condition *kali bic.* 3x was ordered. On November 2<sup>d</sup> he returned, saying he was feeling very ill. On that day Dr. Lambert was asked to examine him, and learning that his cough was now relieved by lying on his back, *manganum* was suggested and given in the 3x dilution. On November 9<sup>th</sup> he reported himself as feeling much better, though there was found to be fremitus at the left base and some impaired resonance. The same medicine was continued, with steady improvement, and on his last visit (December 14<sup>th</sup>) he was much better.

In comparing the respiratory symptoms of these two drugs, we find considerable similarity. Both have hoarseness and roughness of the larynx and morning aggravation, but in *manganum* the hoarseness is more marked, and there is a painful sensation of dryness. Both have, also, headache from the cough. The symptom, “relief from lying down,” appears to be much more characteristic of *manganum* than any other drug, and in the absence of symptoms pointing to *ferrum* or some other remedy, *manganum* should always be given. Lilienthal mentions the following in addition to *mang.* under this symptom: *Acon.*, *amm. m.*, *euphr.*, *lycop.*, *sepia* and *zinc.*—*Hom. World*, February 1, 1896.

**NATRUM NITRICUM IN INFLUENZA.**—As given by Dr. Puhlmann, of Leipzig, the following are the only indications for the use of *natrium nitricum* in influenza: The disease commences in the middle of the day, generally after partaking with good appetite of the customary meal. The general symptomatology resembles a simple febrile bronchial catarrh, which is limited to the upper part of the respiratory tract. The conjunctives are always affected; there is a constant increased lachrymation. The cough is dry in the beginning; but sputum coctum appears as early as the second day, and the larynx is usually affected at the same time, so that the

voice is husky. The tongue in uncomplicated cases is coated white, the urine is acid, clear or reddish, the pulse large, full and soft. Aggravation occurs in the afternoon and evening hours, amelioration in the morning. In such cases *natrum nitricum* relieves always within two days, the cough persisting only a few days longer. If, at the same time, there arise complications of the digestive organs which are manifested by a whitish yellow-coated tongue and constipation, then *natrum nitricum* should be given in combination with *aqua mucum vomicarum*.—*Medical Century*.

**ATROPINE SULPHATE IN ENURESIS.**—Dr. Geo. F. Dunham says: In obstinate cases of enuresis use *atropine sulphate*, one grain to one ounce of distilled water. Of this give one drop for each year of age at 4 and 7 P.M. It might be well to use one-half the above dose to begin with; but it has cured cases for us after the failure of many other apparently well indicated remedies.—*Medical Current*.

**PAMBOTANO.**—The *Homeopathic Recorder* recalls that the late Dr. S. Lilienthal first called the attention of the profession to this drug by a translation sent to that journal. Very little of interest concerning the remedy has appeared since until the following, which is translated for the *Therapeutic Gazette*.

Crespin (*Bull. gen. de Therap.*, August 15, 1895), after a study of the physiology and method of administration of this drug, illustrated by very interesting cases, comes to the following conclusions:

1. *Pambotano* succeeds in many cases where *quinine* and other drugs have been entirely inefficient.
2. The drug is most successful in cases of quotidian intermittent and the simple continued forms of this fever. In chronic malaria it is equally advantageous, but in the bilious form, the pernicious accesses, the neuralgias, it has not given as satisfactory results.
3. In the majority of cases it markedly increases the appetite, and is, apparently, a stomachic far superior to *quinine*.
4. *Pambotano* does not appear to act as a specific against malaria, but rather, by raising the general health and favoring the discharge and elimination of the infectious elements through the skin; this discharge is almost entirely through the skin.
5. This mode of action explains the success of this drug in various forms of infective diseases (la grippe, typhoid fever, etc.), as observed by Valude.
6. The absorption of *pambotano* is always very rapid.
7. It is a drug that is absolutely harmless.
8. When it becomes well known, it will render great service, especially in intermittent, continued and chronic malarial fevers.—*Hom. Recorder*.

**THE THERAPEUTICS OF INFANTILE MENINGITIS.**—According to Dr. O. Edward Janney, Napoleon won most of his great victories by sudden surprises and rapid advances before the enemy were prepared for resistance; and in like manner the onset of meningitis may be met and its advance checked by means of the early recognition of the condition and the prompt application of remedies. The proper ammunition to use in this early skirmish is *ammonium carbonicum*. It will throw the advance guard back upon the main body and produce the formation of a regular line of battle. Or, to put the idea into medical language, the remedy will bring about reaction, put the system of the patient into a more natural condition, thus opening the way for a more careful study of the case and the application of the proper curative measures.

Now for the next step. You sit by the side of the patient and study him. The face is flushed, perhaps, the eyes bright, and showing a tendency to dilation of the pupils. You take his hand in yours; it is cooler than usual. You touch his feet and legs; they also are cool. You notice that the child is restless, his limbs jerk about, and groups of muscles perform a spasmodic dance. He places his hand on his forehead, indicating the location of pain, or else retraction of the head suggests suffering at the base of the brain; fever and thirst are present. You have now sufficient evidence to justify the employment of *belladonna*.

Pain in the head, neck and spine is often a prominent and troublesome feature of meningitis. Even when the child is in a stupor he manifests pain by turning the head from side to side, or by putting the hand to the seat of suffering. When the pain is located in the back of the neck, it is accompanied by a bending of the head backward so as to relieve tension, thus making the first step toward opisthotonus. Older children may complain of dizziness, stiff neck and a sensation as if

the parts affected were alternately opening and closing. Now, when this group of symptoms presents, *coccus indicus* will afford relief.

Sometimes the pain is felt not only in the vertex, but also at the base of the brain, and extends down the neck and to the scapulae. The pain is aching or drawing in character, and is accompanied by exquisite sensitiveness to pressure. This condition demands *cimicifuga*.

When the muscles of the neck are thus sensitive, and the head is thrust backward to relieve pressure, with a tendency to opisthotonus; when the child is aroused from a state of insensibility by sudden violent jerks which shake the body from head to foot like electric shocks, and a strong tendency to spasmodic attacks is evident, the remedy is *cicuta virosa*. Such a selection will be made more in accordance with *similia* if there is also severe gastric pain, accompanied by vomiting and painful distension of the abdomen.

These pains, which seem to dart from the brain through the body and limbs, rendering the tissues through which they pass sensitive to touch, bring *nux vomica* to mind; and should there be present that state of nervous tension which is ready to create a nerve-storm at a touch or noise or jar, our choice of *nux* is a wise one.

In studying a case of meningitis, you will often observe a tendency to convulsions. The muscles, especially those of the forearms and the feet, twitch and tremble, the eyes show a strabismic tendency, and there may even be a slight general seizure. If, with these symptoms it be noted that the eyes lack lustre and are encircled with dark rings, while there is a general sluggishness of peristalsis, the active services of *cuprum aceticum* may be employed to check the tendency to convulsions.

It will sometimes be observed that a patient with meningitis presents indications of passive congestion; a face duly flushed, brain inactive pupils dilated, eyelids drooping, vision clouded, expression lost, muscular power lessened almost to paralysis; the pulse soft, full and flowing. Accompanying this condition oftentimes, is a severe headache, the pain being most marked over one eye and extending upward over the vertex. And with the headache, vertigo is experienced. Under these circumstances, the use of *gelsemium* often yields prompt results.

When cephalgia becomes increasingly severe, and is felt especially in the frontal and temporal regions, sometimes extending to the occiput and back of the neck; when the fever continues high, the pupils unequally dilated, and the eyes show a tendency to be turned up, mild delirium alternating with stupor, we know that effusion is about to take place and that *bryonia* is the Moses that will lead us out.

And so it becomes evident that in order to aid nature in the cure of cases of meningitis, we must be able to group the most meaningful symptoms and, having in mind the group of drug-effects most closely corresponding to these symptoms by opposing, end them.—*Hom. Journal of Obstetrics, Gynecology and Paediology*, March, 1896.

**ARGENTUM NITRICUM IN FUNCTIONAL EXHAUSTION.**—Dr. J. Heber Smith, of Boston, recommends *argentum nitricum* for the conditions attending central nervous exhaustion and consequent functional weakness, as exhibited by sedentary brain-workers. Among the characteristic symptoms repeatedly confirmed in his own practice, are the following:

Despondency; disturbing emotions; automatic performance of ordinary mental tasks and a haunting subconsciousness that they have been doing wrong; adding columns of figures and the like brain-work become wearisome or impossible (as in cerebral anemia); impairment of memory very noticeable; sense of time dragging; distressing mental confusion, with feeling of dulness of the head. There is commonly dizziness in the morning, as if turning in a circle; the patient seats himself to avoid falling sidewise. These patients are the victims of frequently recurring attacks of hemicrania, attended with vomiting and straining, with loud forcible eructations. They suffer from gastric catarrh through wrong habits of food indulgence, characterized by excessive flatulence of the stomach, with acute sense of distension, with pains radiating to chest and back, and violent belching after meals. In cases not fully developed, this truly characteristic belching affords relief. But in time, a kind of gastralgia is developed characterized by enormous distention after eating, attended with anxiety, exhausting nausea, cold sweat, and general throbbing and trembling. The vomiting is commonly of glairy, viscid, sour mucus. There is apt to be marked cardiac arrhythmia, with palpitation on in-

considerable muscular exertion, attended with tremor, especially of the hands. The legs are weak, and there is a sense of awkwardness in their movement, as though they were padded, or wooden, and there is a tormenting formication, as if impending paralysis, by day, with coldness of the hands and feet, from weak heart action ; unsteady, tottering gait ; continuous lumbar pains ; half sided headache ; a pallid, doughy face, with general muscular flaccidity and tendency to oedema complete the picture.

Dr. Smith has obtained his best results with the sixth decimal dilution, prepared with distilled water and starting with the pure crystal nitrate of silver. He repeats the dose three times daily, half an hour before meals. It has proven very helpful in lingering conditions following la grippe, in albuminuria from heart insufficiency, with dyspnoea from exertion, for functional weakness of the spinal cord, and in neurasthenia.

Analogous remedies are *arsenicum*, *phosphorus*, the mineral acids, the ammonium salts, and in a few instances it has been noticed that *zincum phos* follows *argentum* with advantage. *Ferrum* is occasionally of service for the vomiting. *Calcarea phon.* often precedes *argentum* in protracted cases of neurasthenia.—*New England Med. Gaz.*, Feb., 1896.

**HÆMATURIA CURED WITH VENICE TURPENTINE.**—Stanley Wilde records the case of a boy aged 13, who was brought to the dispensary suffering from bloody urine. He had been ailing in this way for two or three months, and had been under two doctors, who had been unable to ascertain the source of the haemorrhage, or to relieve the condition. From the fact that the patient had a more or less fixed pain in the right kidney, and that the urine was passed uniformly mixed with blood, Mr. Wilde concluded that the haemorrhage was renal in origin. The appearance of the urine was like muddy port wine.

He was given *terebinth.* 1x, gtt. ii. om 3 hor., which caused the urine to become clear and bloodless, but there were constant relapses of haemorrhage from time to time. *Berberis* in two-drop doses was then given, which gave relief to pain in the kidney, but did not otherwise help. The boy had no other symptoms, so *terebinth.* 1x was again given for some weeks, but the haemorrhage returned intermittently. He discontinued attending the dispensary, and some few months later, whilst visiting another member of the family, Mr. Wilde asked after the lad, whose mother then informed him that the boy was now quite well, and that she had cured him with Venice turpentine. She said that a neighbor had advised her to purchase two pennyworth of Venice turpentine, to make it into pills with flour, and to give one every night at bedtime. This she did, and by the time the patient had taken ten or twelve pills, the haemorrhage had ceased, and had never since returned.

The Venice turpentine of commerce is a mixture of resin and turpentine. Here is an instance of a stronger dose succeeding where the weaker one failed, or only produced a temporary effect; for the resin need not be taken into account. The moral would seem to be that even though the remedy may be perfectly homeopathic to the case, we may sometimes err in the smallness of our dose.—*Hom. World*, February 1, 1895.

**THE HOMEOPATHICITY OF MERCURY AND IODINE IN SYPHILIS.**—Dr. Oscar Hansen, of Copenhagen, Denmark, says : There exists a great deal of discrepancy among authors as to whether mercury and iodine are homeopathically indicated or not in the various syphilitic affections, and I shall here quote the observations of various authorities. Drs. Helmuth and E. P. Franklin consider mercury and its preparations as truly homeopathically indicated remedies. Dr. R. Hughes thinks mercury to be absolutely homeopathic in affections of the mouth and throat, as also the various affections of the skin (syphilides.) Dr. Carroll Dunham states, in his *Lectures on Materia Medica*, that the ulcers originating from mercury on the gums, on the inner surface of the cheeks, and on the tongue, are attended by salivation, elevated, having a red, irritable surface, irregular without sharp marked edges, bleed readily, have a dirty white covering, and are apt to run together. He furthermore points out the difference between these ulcers and the syphilitic, the latter being circular with well-defined edges. The surroundings are copper colored, and he considers acid nitric more frequently and more successfully indicated than mercury. Yet the syphilitic ulcers will easily bleed. Prof. T. F. Allen, in a dissertation in the *Transactions of the American Institute of Homeopathy*, for 1894, under the title of "An Introduction to the Study of the Preparations of Mercury," states that mercury especially affects the long bones,

but seldom the flat ones. Necrosis and caries will occur in cases of poisoning by mercury. There is some resemblance between poisoning by mercury and lues as to ulceration and destruction of the bones, and exacerbation at night. On the other hand, iritis does not occur in cases of poisoning by mercury, and ulcers therefrom do not at all resemble the initial chancroidal sclerosis. Lues especially affects the bones of the head. Dr. Franklin has decided that mercury is homeopathically indicated, as the resemblance between mercury and lues appears in the skin diseases, the diseases of the periosteum and the bones, the affections of mouth and throat, the enlargement and hardness of the glands, and the reduction of red corpuscles of the blood, with an increased proportion of serum. Dr. McClelland takes the same view in his dissertation, *Homeopathic Treatment of Syphilis*, delivered at the First World's Congress of Homeopathic Congress at Philadelphia, 1876. I shall here only remind my readers of the fact that Dr. Joseph v. Zlatarowitch, at the St. Joseph's Academy, of Vienna (Professor of Pharmacology and Materia Medica), lecturing on mercury and its uses in cases of syphilis, exclaimed, "Why, to be sure, this is sheer homeopathy!" This lecture gave rise to the commencement of his excellent provings of bryonia and agaricus muscarius at the Provers' Association of Vienna, and afterwards he became a homeopathist.

With regard to iodine and kali iod. also, authors disagree. Dr. R. Hughes does not consider it strictly homeopathic, whereas Professor T. F. Allen, in his *Hand-book of Materia Medi-a*, considers it homeopathically indicated in certain stages of lues; and here he is right, for the effects on the throat, the glands, the organs of respiration, and the whole morbid condition show the resemblance.—*Hom. World.* May 1, 1896.

**THE TREATMENT OF SPECIFIC URETHRITIS.**—In the course of an able article upon "Urethritis, with Special Reference to its Diagnosis by Means of the Urethroscope," Mr. Dudley Wright presents a table showing the chief indications of some drugs homeopathic to that disease, including gelsemium, cantharis, cannabis sat., cannabis ind., argent. nit., merc. sol., capsicum, copaiva, digitalis, pulsatilla, thuja occident., clematis erecta, nux vomica and sulphur. In remarking upon this list, he mentions that aconite, though not mentioned in the table, is undoubtedly of use in the acute stage, though he does not know that it causes any special urethral symptoms. Its use in rigors from catheterism is too well known to be further dwelt upon. Besides cannabis, which is shown in his table to cause incontinence of urine, we have another drug which is useful in paralytic conditions of the bladder-neck, left after the acute attack has passed off, namely, dulcamara. Were he asked what remedies were of most use in the attack, he should say that for the first stage, before purulent secretion had become well established, aconite, followed by gelsemium, would suit best, and that, when the flow was established, cannabis sativa would be the remedy most indicated; but it is needless to say that no universal rule should be laid down, as it inevitably leads to that worst of all forms of treatment, routine medication.—*Monthly Hom. Review*, April 1, 1896.

**A NEW TREATMENT FOR EPILEPSY.**—In the *Press Medicale*, of January 1st, Bexhtereff, of St. Petersburg, gives the details of the treatment of epilepsy by a new method, which has been attended with marked success. He puts of the leaves of *adonis vernalis* about 30 or 40 grains in five ounces and a half of boiling water, filters, and adds from 150 to 170 grains of *bromide of potash*, from 2 to 3 grains of *caffeine*, and of this mixture gives from four to eight teaspoonfuls a day in water or sweetened milk. With this treatment he claims to have produced an entire cessation of the attacks, or a diminution in their intensity and frequency.—*New York Medical Times*, March, 1896.

**PAULLINIA SORB. IN DIARRHOEA.**—At a recent meeting of the New York Homeopathic Pedological Society, Dr. Joseph F. Land detailed a case of diarrhoea in a girl eight years old, who was subject to frequent attacks of loose movements. When first seen she had suffered from the present attack for three or four days, and had received enough home and proprietary remedies to thoroughly complicate the case. After giving, as indicated, colocynthis, dulcamara, veratrum album, arsenicum, and phosphoric acid without benefit, the stools were observed to be bloody, with bright green flakes intermixed. On that indication paullinia sorb. 3x was prescribed. Marked and immediate improvement followed, and the patient was soon discharged cured.—*Medical Century*, March 15, 1896.

# THE HAHNEMANNIAN MONTHLY.

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JULY, 1896.

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1796—HAHNEMANN—1896.

BY PEMBERTON DUDLEY, M.D., PRESIDENT OF THE INSTITUTE.

(Centennial Oration delivered before the American Institute of Homœopathy at Detroit,  
Michigan, June 18, 1896.)

CIVILIZATION marks her progress not by dates, but by deeds—not by the rolling of the terrestrial sphere, but by the flaming forth of light and warmth from hearts pregnant with celestial fire. She takes no note of time, save as it marks the uplifting of man, and counts no deeds worthy of remembrance but those which arouse lofty admiration, excite heroic purpose, or minister to human well-being.

So far as history has yet been made, the contemporaneous estimate of the world's worthies has been almost invariably too low. Scientists, discoverers, philanthropists, prophets, the world's upifters, one and all, tell the same monotonous story of oppression and outrage, of the rack and the scourge, the dungeon and the cross. Or, escaping these extremes of persecution, they unfold a tale of social ostracism and public malevolence, of enforced poverty and privation, of daily, living martyrdom. This reiteration of the story of shame and wrong is unfortunate, and yet it is the natural consequence of the con-

ditions and circumstances that have made these noble lives a necessity to human progress and given them impetus and incentive. But for the idolatries of Baal there was no need of an Elisha; no need of a Voice to cry in the wilderness, had every path been straight and every highway plain. But the ignorance, the error, the sin, that forces the outcry—this it is that sheds the Messenger's blood and drives the Prophet to a hiding-place in forest or mountain.

The world seems to have been conscious of the inequity of the estimate it has placed upon the lives and services of its great men, for it has sought to excuse contemporaneous abuse by promising that posterity would do them justice. How this cheap posthumous recognition is to benefit these dead heroes does not clearly appear. As posterity usually measures out her appreciation of departed worthies, not by what they did for the past, but by what their influence is doing for the present, the old debt remains for ever unpaid.

In the life and experience of Hahnemann history was but continuing itself. The doctrine he proclaimed was too antagonistic to the teachings and practice of his age to permit his escape from the common experience of reformers. The application of Hahnemann's homœopathy, like that of Franklin's electricity, was not to attain at once its full development, and it was not possible that it could in a few years supplant an error which had been striking its roots deeper and deeper in the subsoil of prejudice and professional pride for twenty-two centuries.

But whatever may be the world's ordinary treatment of its great men, that accorded to Hahnemann was extraordinary. In the annals of science and art, indeed, it was unprecedented and unique. No medical man that ever lived has been so little understood or so profoundly misunderstood. There is not a single important doctrine to which he gave utterance that has not been grossly misunderstood and grotesquely misrepresented. There never was another physician so venerated or so derided; so honored or so despised; so admired or so ridiculed; so reverenced or so villified; so loved or so hated. No physician ever wrought so toilsomely, none so self-sacrificingly, for the good of his fellow-man, and none was ever so vigorously cursed for his pains. Never was there one who brought richer

material blessings to his fellow, or who was more roundly execrated and imprecated and Billingsgated; never one who cherished a more fervent enthusiasm for the profession of medicine, and yet aroused so intensely the animosity of its representatives.

Neither does there seem to have been any period of his life, or any effort of his intellect, any labor to which he gave his powers, or any investigation he pursued, any discovery he made, or any social, domestic, or professional relation into which he entered, in which he was not made the object of calumny and abuse. As a student and as a practitioner, as a translator and as an original writer, as a chemist and as a surgeon, as an investigator and as a discoverer, in every relation he met the same experience—misrepresentation, vituperation, villification. And not only himself, but his wife, his children, his disciples, his patients, his friends, the government officials who dared to protect him, and the towns and cities that presumed to shelter him, not one of these escaped a measure of the maledictions and anathemas that were thundered against his person. The resources of invective were well nigh exhausted for epithets wherewith to assail him. He was denounced as uneducated, ignorant, illiterate; as a dreamer, a visionary, a lunatic; as a mountebank, an imposter, a swindler; he was charged with ignorance of anatomy, physiology, and pathology. It was said that he wrought out a theory in his own brain, and then ransacked the libraries for material to sustain it; that his doctrines were works of darkness, and their author a fiend from the pit; that he prevented himself from being a great chemist by becoming a great quack; that he was a juggler, a humbug, a deceiver, a fool, a buffoon; that his system was destined to an early death, and was already rotting on the edge of its open grave; all these and numbers of other literary fragrances were showered upon him during his life, and upon his system and its practitioners along the whole course of its first century.

From all the facts thus presented it will be easily understood that it is almost impossible to speak dispassionately of Hahnemann without seeming to assume toward him the attitude of a champion and defender. Almost every important statement of fact that one can make respecting his life, his character or his work, carries with it an accusation of gross and glaring

falsehood against some one or more of his detractors. Yet it is no part of the purpose of this address to attempt a refutation of these calumnies. They have long ago demonstrated their powerlessness to harm the venerated name of Hahnemann, or to arrest the progress of that art of healing with which, under God, he was permitted to bless the human race.

Because the world's reception of Hahnemann was unique and unparalleled, therefore to the student of social science Hahnemann himself becomes a phenomenon. There must have been something in the man, in his character, his work or his doctrines, so out of the common that it impelled his contemporaries, in their dealings with him, to lay aside the guidance and restraints of ordinary action. We must, at least, admit either that Hahnemann furnishes an unusual theme for the consideration of the historian and the socialist, or else that his persecution suggests a study for the psychologist, or perhaps the alienist. The world's treatment of Hahnemann, of course, cannot be justified; but can it be explained?

The one subject of special interest in connection with Hahnemann's childhood and youth is his education. Born in Meissen, near Dresden, in 1755, he spent several years in the public and private schools of his native village. His studies, which were interrupted at intervals, included Latin, Greek, Hebrew, English, French, History, Physics and Botany, besides the branches ordinarily pursued. At the age of twenty he went to the University of Leipsic with twenty thalers in his pocket. All the funds necessary for his support and education from this time forth were earned by the young hero, by teaching German and French and translating. He had already conceived a predilection for medical studies and made use of every opportunity for acquiring knowledge in its various branches. During the two years in Leipsic he translated five medical volumes from English into German. At twenty-two he went to Vienna to pursue his medical studies, and afterwards received an appointment as family physician and librarian to Baron von Bruckenthal, the Governor of Transylvania. Here he catalogued the baron's immense collection of books and rare manuscripts, and, as said by his biographer, "here he acquired that extensive and diverse knowledge of ancient literature and of the occult sciences of which he afterwards proved himself to be a master,

and with which he astonished the literary and scientific world.” He finally received his medical degree at the University of Erlangen in August, 1779, at the age of twenty-four. He had succeeded in acquiring that general information common to the well-educated German youth of his time, together with a knowledge of medicine; besides which he had (at the age of twelve) been entrusted to teach the rudiments of the Greek language in the Meissen school; he had prepared an herbarium of the plants of his native Saxony; had translated numerous volumes for the German publishers; had catalogued one of the largest private libraries in Europe, and arranged a “matchless collection of ancient coins;” had familiarized himself with the general scientific literature of the ancients and had acquired a practical working knowledge of ten languages—Latin, Greek, Hebrew, French, German, English, Spanish, Italian, Arabic and Syriac, and a rudimentary acquaintance with Chaldaic. This is the man who has been repeatedly described in medical literature as an illiterate ignoramus.

Whether we accept or reject the theory that Hahnemann was raised up by Providence for the work to which he devoted his energies, it is not difficult to find evidence that almost every event and circumstance of his history seemed to adapt the man for his work, or to compel his devotion to his task, or to secure the needed facilities and opportunities for its accomplishment. His birth and parentage, his passionate fondness for literary and scientific studies, the poverty of his youth and mature manhood, the intense integrity of his moral character, his deep religious convictions, the independent and critical quality of his mental activities, his wonderful memory, his broad intellectual grasp of great questions, his unusual mastery of multitudes of details, his fondness for accuracy and completeness in observation and expression, his powers of analysis and classification, the antagonisms that he endured, the difficulties he encountered—in short every quality and condition that distinguished or environed him—seemed to enter into combination to adapt and complete the worker and to assure the progress and consummation of his work.

But Hahnemann’s training for his great work was, even yet, not complete. He was learned in the “wisdom of the schools,” but the main task of his life was to be wrought almost entirely

outside these scholastic limits. He needed an education of a thoroughly practical sort, and we know how he obtained it.

His biographers—one of them being himself—have informed us that after his graduation, he spent a brief period in the copper-mining region of Hettstadt, in Saxony, and that in 1781 and 1782 he was living at Dessau, engaged in the study of industrial chemistry, and of mining and smelting; at the same time following his chosen profession of medicine. He soon became widely known as an original investigator in chemistry and added immensely to the world's useful knowledge of that art. In order to estimate Hahnemann's services to the world in this field, we must consider the status of that branch of knowledge at the period of his principal chemical labors and discoveries. For this information we are largely indebted to the historian, Ameke, of Berlin.

Strangely enough, the old doctrine which prevailed before the Christian era—that all matter is composed of four elements: fire, air, earth and water—came down to the close of the eighteenth century. The last three decades of that century witnessed a bitter controversy between the adherents of that ancient view, or a modification of it, and those who were beginning to perceive its fallacy. The particular form of the doctrine as it was then held was ascribed to Stahl, but was in reality an offshoot of the theory held in the days of old Aristotle himself. One astute writer declared that water does not belong to the elements, because the Bible says that “in the beginning God created the heavens and the earth,” but that it makes no mention of water, and that, therefore, water is but a modified form of earth, rendered fluid by warmth. Becker, in the seventeenth century, had written of what he named the “inflammable principle,” and Stahl afterwards wrote learnedly about it, but changed its name to “phlogiston.” It was, under both names, the same old elemental “fire” of Aristotle and Hippocrates. Any thing that would burn contained “phlogiston.” Ignition, or flame, was the escaping phlogiston. Chemists were busy trying to resolve water into earth and searching for the “fundamental essence” of matter; and there were still a few alchymists striving to transmute the baser metals into gold. Scheele was endeavoring to extract the coloring matter from Prussian blue; Westrumb was discovering, or

thought he was, that acetic acid was the basis of all the vegetable acids, and was asking whether phosphoric acid lies concealed in nitric acid. Winterl made experiments which, he said, showed that copper consists of nickel, plumbago, silica, carbonic acid and a substance which passes off in boiling. Kirwan held that muriatic acid was composed of carbonic acid plus phlogiston; and so the whole department of chemical learning was borne down by a limitless avalanche of theories and speculations which had their only basis in the vain conceptions of their promulgators. Such was the so-called science of chemistry in the early days of Hahnemann's active career. We may be very sure that the so-called science of medicine was in an even worse plight.

But in one particular chemistry was about to outstrip her sister art of medicine. The famous French chemist, Lavoisier, had introduced into the art an entirely new factor—the balance. He had demonstrated that in all chemical operations and processes there is neither a gain or a loss of weight of the materials concerned in the operation. He proved that water is not a kind of earth, but is composed of two distinct elements, oxygen and hydrogen, and he administered a death-blow to the doctrine of the ancients, that fire is an element of material nature. Perhaps the most important of all his services was the introduction of accuracy and exactitude into chemical researches, precisely as Hahnemann did into medical investigations. In this particular Lavoisier was to Chemistry what Hahnemann became to Medicine.

Between the followers of Lavoisier's exact methods and doctrines, on the one side, and the advocates of the old "phlogiston" theory on the other, there arose a bitter contention. Hahnemann, who had already made a reputation for himself as a chemist, insisted that there could be no solution of the questions at issue except by exact experimentation. This proposition of the great chemist is significant, because it is in strict keeping with his subsequent career and record as a medical investigator. This chemical controversy did not assume the virulent type of the antagonism that arose against the reformation in medicine. Hermbstadt, it is true, complained that he had often advocated the new chemical doctrine at the expense of his honor and good name, and had been "more than once

saluted as a ‘quack,’ an ‘imbecile,’ a ‘propagandist’ and an ‘anti-phlogistic town-crier’;” and history records that Lavoisier himself, in 1794, fell a victim to the diabolical madness of the French revolution. There is no good reason, however, to believe that his peculiar chemical doctrines had any influence in bringing about his butchery by Robespierre. Prof. Gren said that his principal objection to Lavoisier’s system was that “It opposes obstacles to the progress of natural science.” It is a little curious that Hufeland couched one of his objections to Hahnemann’s doctrine of homœopathy in almost the same language, saying that “It would have an injurious effect upon the study of medicine.” That these two reformations, occurring almost side by side, did call a halt upon the heedless elaboration of baseless theories, is their crowning commendation. It was precisely what was needed.

Among the more important services that Hahnemann rendered to the science and art of chemistry, the following may be enumerated:

In 1784 he translated Demachy’s two-volume French work on the “Art of Manufacturing Chemical Products.” This work was originally published by the French Academy, because it revealed many of the processes of industrial chemistry which had been kept secret by manufacturers, and particularly by the Dutch. Both France and Germany needed the knowledge of these secrets, and it is mentioned as an additional service rendered by Hahnemann that by *his* translation he not only gave this important information to his countrymen, but added numerous notes and suggestions for improving and extending the knowledge of industrial chemistry until, in the language of one of his reviewers (*Crell’s Annalen*), “The notes are greater in amount than the text, and more important.” The work, in the original, abounds with errors, many of which Hahnemann pointed out and corrected. In many places the author’s obscurity of statement is cleared away and his incompleteness supplemented by Hahnemann’s wider acquaintance with the subject. Hahnemann described an improved apparatus, invented by himself, for testing the specific gravity of liquids, and a method for improving the draft in chemical furnaces. He suggested changes, which were afterward adopted, in distilling apparatus; gave accurate directions to the potter and mason for

constructing, shaping and setting special retorts; contrived a special mode of distilling aqua fortis by which the retorts were prevented from bursting; proposed a new and better method of purifying saltpetre; introduced new tests for muriatic and sulphuric acids; indicated a means of separating magnesia from the brines of salt-works; determined, carefully and accurately, the solubility of numerous salts at different temperatures; discovered, for the first time, that white lead is a combination of metallic lead and carbonic acid, and not of lead and vinegar, as had been supposed; he was also the original discoverer of the chemical change necessary for the conversion of alcoholized liquids into vinegar. And, neither last nor least, he advocated the crystallization of tartar emetic for the purpose of securing a standard of reliability for that important medicine. This procedure is now universally employed in pharmacy.

These are a few—only a few—of the valuable contributions made by Hahnemann to chemistry and industrial technology. His name, however, is rarely mentioned in chemical literature in connection with these discoveries, partly because certain writers have been interested in keeping the discoverer's name from the knowledge of the world and partly because others have been so intent in blazoning his more brilliant exploits in the field of therapeutics that they have almost lost sight of his services in other departments of human achievement.

There are two other services rendered by Hahnemann to be mentioned before we take up his original investigations on therapeutics—namely, his treatise “On Poisoning by Arsenic; Its Treatment and Judicial Investigation,” and his discovery of the “Wine Test.” He began his investigations relating to arsenic by showing that the tests usually employed were unreliable. He next made a series of experimental studies of the subject, which resulted in the demonstration of the value and reliability of three essential tests for this dangerous drug. These tests were lime-water, acidulated sulphuretted hydrogen-water and the ammoniac-muriate of copper. Water impregnated with sulphuretted hydrogen had been previously used for the purpose; but its action was extremely uncertain until Hahnemann hit upon the expedient of acidulating it, thus rendering it one of the most delicate and efficient methods yet known to science. Hahnemann was also the first to employ alkaline solutions—

the chief method still resorted to—to distinguish arsenic, antimony, etc., from mercury, copper, etc. Still further, in the manner always characteristic of his methods, he determined accurately the limit of activity of all the agents he employed. These investigations added immensely to the existing knowledge of medical jurisprudence as it relates to criminal poisoning by the compounds of arsenic, and the knowledge thus gained is universally employed to-day.

The second of these special discoveries for which the world is indebted to Hahnemann is what has been known as the "Hahnemann Wine-Test." In those days wine was frequently adulterated with sugar-of-lead, giving rise to colic, emaciation, paralysis and sometimes death. The serious nature of these results naturally aroused a strong public sentiment against the adulterators, and whenever they were detected they were subjected to severe penalties. Unfortunately, the tests that were employed to detect the presence of lead yielded the same results in the presence of other metals. A case is cited in which a merchant suffered a heavy penalty and the loss of his business because of the presence of iron nails in his wine casks, and similar judicial errors were said to have occurred quite frequently. On a certain occasion a large number of merchants were to be tried for adulterating their wines with lead, and Hahnemann determined to discover, if possible, a method by which lead, iron and other metals in alcoholic and watery solutions could be accurately distinguished, one from another, that the innocent might no longer be compelled to suffer with the guilty.

There is no need to recite here the story of his investigations and experiments. It is sufficient to say that he soon found that one of the tests he had discovered for the arsenical compounds—water saturated with sulphuretted hydrogen—yielded a precipitate of sulphide of lead, or of iron, as one or the other of these metals might happen to be present; but he also learned—and herein consists the peculiar value of his discovery—that the addition of a few drops of sulphuric acid redissolved the iron precipitate, while it simply deepened the dark yellow color of the precipitate of lead. German jurisprudence was thus supplied with an unfailing resource for distinguishing noxious adulteration with lead from the inadvertent

and harmless presence of iron. Either in the same year or the year following (1788 or 1789) Fourcroy, a famous French chemist, recommended sulphuretted hydrogen as a test for lead in wine; but Fourcroy knew evidently no method for distinguishing lead from iron, and the best he was able to do was to detect the presence of lead in the proportion of one part in one thousand, while Hahnemann's method showed its presence in the proportion of one part in thirty thousand.

The whole story of the “wine test” has not yet been told. The experimentation showed that the method was also useful in demonstrating the presence of antimony, silver, mercury, tin, bismuth and perhaps other metals; and while there is no longer any necessity for employing it in the judicial inspection of wine, because the practice of lead adulteration has long since died out, yet it is in daily use as an indispensable agent in every chemical laboratory and in multitudes of industrial establishments throughout Europe and America. Probably not one in a hundred of these chemists, manufacturers and pharmacists who are employing it every day have the slightest suspicion of the fact that it originated with the same individual as did that peculiar mode of medical practice known as homœopathy.

We have not mentioned—nor is there time to do more—Hahnemann's services as a surgeon, as a public sanitarian, or as one of the very earliest advocates, if not the pioneer, of the substitution of kindly and humane methods of treating the insane for the barbarous and cruel methods of his predecessors. In all these departments of service he won a place among the progressive practitioners of his time.

We now approach a far more important and interesting part of Hahnemann's life and work—his career as a medical investigator and the astounding results of his researches.

It must be borne in mind that at the period of which we speak—1780 to 1810—Hahnemann stood as a recognized associate of the leading savants and literati of Europe. In matters pertaining to industrial technology, chemistry, surgery, pharmacology and medical practice, as well as in the languages and learning of the ancient world, he had vindicated his right to form and express an opinion. When he spoke on any of these subjects, men of learning gave him respectful attention. The

scientific journals of that period abound with laudatory allusions to his name, to his observations and discoveries as a chemist, and to his critical translations of medical and chemical works. It is not to be wondered at, therefore, that the enunciation of his new medical doctrine in 1796 aroused the curious and eager attention of all Europe. Had their author been the obscure and unlettered man that certain American writers would have us believe, it is not probable that they could have excited such wide-spread attention or elicited such a storm of criticism. As Ameke expresses it, " Amidst the confusion of hypotheses and speculations, a weak voice would not have been listened to."

While the medical practice of Hahnemann's day was immensely superior to that of the preceding centuries, the mode of medical thought did not differ in its essence from that which prevailed in the time of Hippocrates, four hundred years before the advent of Christianity. Lest this statement should be considered extreme, let us be somewhat specific. And first let us institute a brief comparison.

Twenty-two centuries apart there stand two figures ever to be prominent in medical annals—Hippocrates of Cos and John Brown of Edinburgh. The one is lauded as the "Father" of that "Rational Medicine" which is said to have come down to our own day. The other is the author of the most popular of the "systems" of medical practice in prevalent use a hundred years ago. Take these two distinguished men, or rather take the basis on which their "systems" were founded. In what essential respect do the modes of their conception and propagation differ? In order to answer this question clearly it will be needful to mention, briefly, a few of the systems or theories prominent in the intervening period.

Pythagoras (B.C. 500) probably originated the doctrine that the four elements—fire, air, earth and water—composed the human body. At least he originated the doctrine that disease consists of a lack of natural harmony in the proportion of these elements. That was his "pathology." It was not a very "scientific" pathology, but he made it the basis of his medical treatment, and that constituted his treatment "rational," as the term is understood to-day. That is, he had a "basis of reason" for his treatment, and the whole medical profession, of all

schools, since that day, has plumed itself upon the “rational” quality of its medical treatment. One hundred years later Hippocrates of Cos conceived the idea that the body is subject to four conditions: heat, cold, moisture and dryness, and that disease originates from variations in these conditions. This “theory” was his guide to treatment, and we call him the “Father of Medicine.” His followers originated the conception of the “four humors,” and from their “humoral pathology” devised a humoral treatment. Next, disease was said to be due to a “materia peccans,” and the treatment must, forsooth, drive this offending matter out of the body. Following this theory came Asclepiades, of Bithynia, with his beautiful conception of a system of invisible pores permeating the body, and of diseases arising from obstruction or relaxation of these pores, together with a system of medication designed to remedy the porous difficulty. And thus we might go on to speak of Themison and his “Methodistic” school, of Agathinus and his “Eclectics,” whose doctrines embraced all the notions and theories gathered from the physicians of Egypt, Arabia, Greece, Assyria and the whole region covered by Roman conquest, and whose laurels were ruthlessly appropriated by his pupil, Galen, whose name, covered with unmerited glory, has come down to our own day, who sought out and gathered in other men’s notions and discoveries, much as some of his disciples are suspected of doing in these days, but who probably never made an important medical discovery in his life. Every one of these men, and dozens more, conjured up some imaginary theory of disease and based thereon a “system” of treatment. Perhaps it really was “rational;” but let us see how this—the “medical thought” of that age—appears when examined in the light of what we call “modern” methods.

First, it will be easily seen that these so-called theories of disease—these conceptions of the “causes” of disease, of its “essence” or of its “conditions,” had no foundation in observed facts. They were not inferences deduced from things seen, or heard, or felt; they were mere phantastic conceits evolved from the inner consciousness. They were not discoveries; they were inventions. They required no toil, involved no laborious research, came not forth through the travail of perilous experimentation. The originator of any one of them

might have retired to his bed at night, conjured up in his fancy the whole of his beautiful scheme of disease and of its treatment, and have arisen in the morning refreshed as usual.

The second criticism that modern knowledge offers to this method of the ancients is: That their acquaintance with the real properties of drugs was too limited to enable them to apply these agents to the cure of disease, even had their "theories" of disease been correct. In other words, it was proposed, and perhaps expected, to obtain a certain specific result by applying an agent whose properties and powers were almost unknown to a condition or circumstance whose very existence was only guessed or assumed, and which had no basis of demonstrated fact to support it. This it is—so we are told—that constitutes Hippocrates, with his four elements, his four states and his four humors, and Galen, with his muckrake, the "Fathers of Rational Medicine" unto this day.

It must not be supposed that these two were the only illogical features of this old medical proposition. There is another, more absurd than either, of which we will speak presently.

From the time of Galen, at the end of the second century, to the close of the fifteenth century, there was little progress made in the art of healing diseases by medicines, save that a few new remedies had come into use and a few new properties had been observed in the drugs anciently employed. Of real scientific progress there had been none at all during the entire intervening period. We are speaking, not of anatomy, physiology, pathology or surgery, but of medicine proper—the healing of diseases by means of medicines. In this department there were in vogue the same crude, halting, stumbling, blundering, speculating, theorizing, dreaming methods as of yore. The whole history of medicine as a science was yet to be written. The Roman world had lapsed again into superstition and the sick once more sought help in sacrifices, prayers, incantations, and the consecrated touch of the priesthood. Medicine and sanitation were alike neglected; men lived amid the perils of putrescent filth and unnamable vices, and, as a consequence that now awakens no surprise, contagions and pestilences raged among them and swept whole communities from the face of the polluted earth.

Before the end of the sixteenth century, Vesalius, Sylvius

and Servetus had, by their researches, prepared the way for Harvey's demonstration of the circulation of the blood. From that time the study of physiology aroused universal enthusiasm, and, as a consequence, physiological dogmas became the bases of medical treatment. The later development of chemistry also had a share in these speculative results, one of which took the form of a theory of a struggle or contention going on in the body between the acid principles and the alkaline principles, and when the "acrimony" of the one prevailed over the acrimony of the other, disease resulted which must needs be treated by acids or alkalies, according as one or the other happened to be the "under dog in the fight." This was during the first half of the seventeenth century. Toward the middle of the eighteenth century, and near the time of Hahnemann's birth, Stahl advanced his hypothesis that the protective power of the body is a rational and thinking soul, recognizing the invasion of disease and directing the forces of nature to resist and expel it. The soul was the healer of the body and medical treatment was almost discarded. Stahl seems to have come very near to being a Christian Scientist, exhibiting the necessary dearth of science and the requisite scarcity of Christianity.

Thus we see that whatever happened to be the fashion in the world of thought was promptly made the basis of medical treatment. And now, leaving out of notice the long succession of fanciful theories respecting disease and the absurd modes of treatment designed to accord with these theories, we come down to Hahnemann's time, and naturally ask ourselves the condition of medicine at that most important period. We find two names prominent, Cullen and Brown; and they were rivals. Cullen made himself believe in the old doctrine of spasm and atony as the causes of disease, and adapted his remedies to that view. Brown, infatuated with Haller's recent discovery of what is known as the "irritability" of muscular fibre, devised the ingenious doctrine that all diseases are due to either an excess or a diminution of the natural irritability of the body, and that, therefore, remedies should be of two kinds, one to antagonize each of the resulting conditions.

Now, let us return to a question asked earlier in the course of this address—namely, taking Hippocrates of Cos and John Brown of Edinburgh standing as prominent medical figures twenty-two

centuries apart, the one four hundred years before Christ, the other eighteen hundred years after Christ, we ask, In what essential respect do the modes of their medical thought differ? In the development of medicine as a science, in what particular does the method of the later physician show any advance or improvement upon that of the former? Hippocrates, from what he knew of the facts and phenomena of nature, constructed a theory of the "essence" of disease. So did Brown. Hippocrates made no researches nor instituted any experiments to ascertain if his doctrine had a substantial basis in fact. Neither did Brown. Hippocrates based his views of the treatment of disease upon his conception of its essence. So did Brown. Hippocrates classified drugs to suit his fantastic conceptions of disease, instead of upon their manifested properties. And so did Brown. Hippocrates never made any systematic researches into the pure properties of drugs by means of experiments from which the vitiating influence of disease had been excluded. Neither did Brown. Hippocrates did not know, nor did he seek to know, whether there existed any curative relation between the powers of a drug and that which he called the "essence" of disease. Neither did Brown. Nor, indeed, did any one of the fanciful, castle-building visionaries from Pythagoras down to Cullen. They were all alike inventors. And the earth was chock-full of their inventions.

We have already mentioned two fallacies in the logic of this speculative medicine: first, that its theories of the essence of disease were pure assumptions, utterly without substantial support or evidence of truth; and, second, that the treatment of these hypothetical diseases—these conditions which existed only in the imagination of the physicians—was to be accomplished with agents of which but little was known. But there was a third defect in the chain of argument on which this old doctrine and practice hung, and it is this: That there was not one jot or tittle of evidence known to exist that any drug had power to cure any disease simply by acting on what was called its "essence," or by antagonizing the "conditions" causing or accompanying the disease. The failure to recognize and appreciate this fact constituted the greatest absurdity in the whole proposition. To what extent these three fallacies are influencing medical thought and retarding medical progress to-day is a

question of vast significance; but it does not belong to the present discussion.

While there had been some important improvements in the medical art, in the science there had been none whatever for twenty-two hundred years. Medicine consisted of a vast conglomeration of assumptions, conjectures and metaphysical conceits, on which as many fanciful modes of treatment were founded, and to these were added a few observations of cures by drug action. That was all. And that was the medicine to which Hahnemann was introduced.

And what was Hahnemann? A student from his cradle, a critic from the beginning of his scholarship, an original investigator in every department of study in which he engaged, taking nothing for granted, accepting nothing short of actually observed facts as a basis of scientific doctrines, skilled in the art of searching out difficult problems, logical, accurate, thorough, exacting. That was medicine. This was Hahnemann. What was there in such a medicine to attract the respect or hold the confidence of such a man? Before he was thirty years old he had attracted attention by his keen criticism of the more prominent medical delusions of the day, and especially showed the logical and philosophical bent of his mind by insisting upon a medical art based directly upon facts and not upon hypotheses.

It is not difficult to follow the direction, nor even to perceive the guiding intellectual conceptions, of the whole progress of his independent researches. Those who assert and believe that Hahnemann simply devised and invented one more theory of medicine in the same manner as did his predecessors and as did some physicians of a later time, know almost nothing of the real history of his labors and achievements.

About the first independent position assumed by Hahnemann in relation to the practice of medicine was his opposition to the custom of combining two or several drugs in a single prescription. In this particular he was preceded by Storck, Cullen, Alexander and a few others, and prominently by Hippocrates. Hahnemann cites these authorities in support of his own views and practice. In 1797 he wrote a vigorous pamphlet on the subject, in which he insists that the necessity for "simplicity in prescribing constitutes the first law of the physician." His

reasons for demanding the use of the single drug, in preference to mixtures, were : that it furnishes the only method by which the physician can know what the remedy has accomplished, or which drug has been useful in the treatment; that a union of two or more drugs in the human body rarely, perhaps never, yields exactly the natural effects of each of the component drugs; that a drug which is not actually needed in a prescription must always work injury to the patient; that the administration of several drugs where but one is needed, is an indication that the physician does not know which the true remedy really is, and the use of such a mixture renders it impossible for him to learn. But the paramount reason assigned by Hahnemann for the use of simple and single drugs is the utter impossibility of ever bringing medicine to a condition of exactitude or certainty unless this method be followed. He claimed that no human power could ever arrive at exact knowledge of the curative properties of any drug so long as that drug should be given in combination with, or the active presence of, any other agent having power to cause disturbances in the human economy. This reasoning involved a fact self-evident enough to have convinced any physician of logical tendencies; yet the adoption of the method has made but slow progress. Meanwhile Hahnemann's reasons and argument remain unshaken and unrefuted. That poly-pharmacy is, or ever can become, the method of scientific therapeutics is not conceivable, much less demonstrable. The "single drug" was the essential first step in the progress of therapeutic discovery, without which Hahnemann himself could have accomplished but little. It was absolutely requisite, not only to all useful experimentation, but to all valuable observation.

How did it happen that Hahnemann began his independent investigations ? Let him tell the story in his own words. After speaking of his medical studies and the beginning of his practice, he goes on to say :

"It soon struck me that in the practice of medicine I was called upon to admit a great deal that was not proved. If I was called to attend a patient I was (expected) to infer from his symptoms that a certain condition of the internal organs existed, and then select such a remedy as the medical authorities asserted would be useful." Again, he says : "It was agony for me to walk

always in darkness, to prescribe according to such and such a hypothesis concerning diseases, and to administer substances which owed their place in the *materia medica* to an arbitrary decision. I could not conscientiously treat unknown morbid conditions by these unknown medicines, which, being very active substances, may easily cause death or produce new affections and chronic maladies. To become thus the murderer or tormentor of my brethren was to me an idea so frightful and overwhelming that soon after my marriage I renounced the practice of medicine, that I might no longer incur the risk of doing injury, and I engaged exclusively in chemistry and literary occupations. But I became a father. Serious diseases threatened my beloved children, my flesh and blood. My scruples redoubled when I saw that I could afford them no certain relief."

But Hahnemann, to use his own words, "felt sure that God must have ordained some certain method of healing the sick." And so, he further tells us: "I determined to investigate the matter for myself from the very beginning."

In the *Organon of the Art of Healing*, first published by Hahnemann in 1810, he gives us in Section 3 the key to the logic of medical science. In that section he says that the physician needs to understand three things. First, he must understand what it is that is curable in disease. Second, he must know what is curative in drugs. Thirdly (and herein the world had no knowledge worth mentioning until Hahnemann taught it), the physician must be governed by distinct reasons in adapting what is curative in drugs to what is curable in disease. Here is the whole of medical science in a nut-shell: What is curable in disease; what is curative in drugs; what are the "reasons"—the laws, rules and principles—that must guide us in adapting the one to the other. Herein is embraced the truth, the whole truth, and nothing but the truth, of the science of medicine as it relates to the cure of diseases by drugs. This is the strong foundation on which it rests and must always rest.

Now let us follow this logical scientist a little farther. We have already seen that when the famous French chemist, Lavoisier, was contending with the advocates of the old "phlogiston theory," trying to demonstrate to them that fire had no place as a natural element, and the dispute had waxed bitter,

Hahnemann insisted that the war of words was but a waste of time, strength and good temper, and that it was not possible that the question between the scientific Frenchman and the chemical antediluvians could ever be settled except at the bar of scientific experimentation. It was the only attitude that a scientist could take. Now we find that he took precisely the same position respecting medical questions; that he insisted upon experiment and observation as the only acceptable basis of therapeutic art, and that he would not even consent to admit a theory or assumption *between* observation and experimentation on the one side, and the application of drugs to disease on the other. What was known absolutely of drugs was to be applied directly—not intermediately—to what was absolutely known—not guessed—of the disease. In the treatment of disease, conjecture and assumption were to have no place whatever *anywhere*. They were to be shut out of all relation to practical therapeutics, just as effectually as the modern chemist bars them out of his laboratory.

But we must follow this wonderful leader farther yet. He had already asserted the importance and necessity of employing but one drug at a time in all therapeutic operations. He subsequently carried this precaution into all his drug experimentation, and for a similar reason—that the results of an experiment might not be vitiated, and thus become misleading and deceptive through the modifying influence of any other agent. Following out this idea, he made his investigations of drug properties by experiments on healthy persons, lest the presence of disease, like the presence of an adventitious drug, might modify the processes or symptoms of his experimental drug, and so vitiate the whole operation. Here again, there was to be no theorizing; nothing but pure experimentation. He proposed that the physician's acquaintance with medicine should be knowledge, not fancy; certainty, not conjecture.

Yet one more step remained to be taken—to learn, if possible, whether there exists any constant relation between the curative properties of a drug and the curable phenomena of a disease. The old medical theorizers did not know, and did not appear to care, whether such a relationship existed or not; but Hahnemann well knew that if medicine was ever to rest on a basis of scientific accuracy and certainty, it could only be

through the discovery and appreciation of some such relation or relations. Hippocrates had long ago said that medicine could cure diseases on the principle of similars as well as on that of contraries. In the introduction to the *Organon* Hahnemann cites this statement, and also quotes from several other authors to show that they had entertained a similar idea, and then he adds, "So near had the great truth sometimes been approached by physicians. But only a transient thought had been bestowed upon it." Hahnemann, in his earlier days, probably regarded this idea of curing by similars as but another of the baseless medical dreams that had floated down through the deep slumber of the Dark Ages. To answer the question of a curative relation between drugs and diseases, he, at any rate, began a series of investigations for himself and in his own way. He knew that his final researches could not be conducted in the dissecting-room of the anatomist, or the laboratory of the physiologist or chemist, nor in the philosopher's grove or the hermit's cavern. He knew that the final questions must needs be asked and answered at the bedside of the sick. There is no need to rehearse the story of Hahnemann's translation of Cullen's *Materia Medica* in 1790; of the critical questions he asked of its author, of his foot-note to the article on Cinchona; of his self-inflicted experiments with that widely-used drug; of his succeeding experiments with other drugs; of his observations of the effects of these drugs upon the sick; of his comparisons of drug symptoms with disease symptoms; of his researches in the vast field of medical literature for materials for classification, or of the slow and careful and guarded conclusions reached. It required six years, yea, six times six; and how can we tell the story in a few minutes. We can only repeat the conclusion of the whole matter as he gives it in the 25th section of his *Organon*. He says:

"But now actual experience, the only infallible oracle of the medical art" (how intensely Hahnemannian!), "teaches, in every carefully conducted experiment, that *that* drug, proved by its effect upon healthy persons to produce the greatest number of symptoms similar to those found in a case of disease, will rapidly, thoroughly and permanently cancel and turn into health the totality of symptoms of this diseased condition."

He had completed his three-sided investigation. He had

discovered and demonstrated a constant curative relation between the manifestations of drug properties and the manifestations of disease. Medicine had at last assumed her rightful position among the natural sciences, her foundations resting upon the bed-rock of experimental, demonstrable truth.

This is Hahnemann's Medicine. The other is "Rational" Medicine. Look on this picture, and on that. How do we like the comparison? Comparison? What is there to compare? They call this a "New System." It is a new Art, a new Science. It is not an outgrowth, not an off-shoot. It is a New Creation. It is *the* Science of Medicine. Before *this* Science of Medicine there was no "Science" of Medicine. Before this there was Chaos. Medicine was "without form, and void, and darkness moved upon the face of the deep." And some of us believe—reverently believe—that "God said, 'Let there be light.' And there was light."

It has been said of Harvey, that he did more than discover the circulation of the blood; he taught men *how* to discover it—how to make investigations in Physiology. With equal truth it might be said of Hahnemann that he did more than discover and prove the existence of the Law of Similars: he taught the world *how* to discover it—*how* to investigate the underlying laws and principles of therapeutic application. Before beginning his experimentation it was necessary for him to lay down, for his guidance, the rules of procedure demanded in the solution of the difficult question which confronted him, *how* to study disease from the view-point of the scientific therapist; *how* to investigate the properties of drugs experimentally, and *how* to exclude every factor that might modify the process or vitiate its results; *how* to ascertain the relations existing between the known properties of drugs and the known phenomena of disease. This preliminary stage of his labors displayed, in the highest degree, the unerring discernment, the endowment of genius, which characterized the man. This portion of his work was necessarily deductive; but it was guided by the clearest conceptions of scientific laws and principles. Had Hahnemann's work stopped at this point, had he simply laid down the rules which must guide and determine such investigations as he proposed to make, and had he then been called from his earthly labors, ere the conception of the Law of Simi-

lars had dawned upon him, a thousand different inquirers, working along these lines and under these rules, would have made the discovery independently of each other, and inevitably; and Hahnemann's name would still be worthy of the proudest monument that human taste and skill could design, or that wealth and toil could rear in his honor.

Almost every famous discoverer that history mentions took up his search where some predecessor had laid it down, or else was able only to prepare the way for the feet of a successor. Rarely, indeed, has it fallen to a single individual to begin and complete an important revolution in science or art. Herein the work of Hahnemann was remarkable. He found Medicine devoid of scientific features. He left it with its scientific future practically assured. His work related to the whole domain of the healing art. If asked to state, in a single sentence, what he did for his profession, the answer would be: "He first applied to medical research the principles and rules which direct and govern other scientific investigations." Hence his field was as broad as the devastations of disease. Other men have explored here and there a section or a subdivision of Medicine, and they have done well; but Hahnemann cultivated a domain as vast as the needs of diseased humanity. He opened up an empire.

We need not dwell upon the hard experiences of this heroic, self-immolating devotee of humanity. We have already mentioned the pecuniary difficulties that environed his early years, but these were a help rather than a hindrance to his determined, indefatigable nature, and only stimulated his self-reliance and self-discipline. Yet it is well not to forget the opposition he encountered, the misrepresentation and defamation that assailed him at every turn, the conspiracies formed against him, the schemes devised to prevent the people from securing the benefits of his researches, the legislative antagonisms to frustrate him, and the cunningly devised civil processes to impede and thwart the beneficent progress of his work. We remember that he was driven from his home, hounded from village to village and persecuted even unto strange cities. We recall his forty years of wandering in homeless exile. We see him toiling throughout the whole of every alternate night to eke out a scanty subsistence for his children; we see him so

reduced in purse that he weighed out the bread to each member of his family, denying himself that his sick child might have a double portion; we see him transporting his simple belongings away from the scenes of his persecution, pausing on the way to lay in its grave among strangers the body of his loved child, and turning away with a heavy heart to pursue his wearisome search for a home where he might labor in peace—a home that he never found till he was four-score years old. We see him putting aside the hope of wealth, of preferment and of the distinction that he might have had for the asking; contemning the “bribery of praise” and welcoming poverty and privation, professional enmity and official intolerance, that he might bear to a disease-stricken humanity that commission of healing which he firmly believed he had received as the loving gift of the Almighty, and laying his remains at last beyond the borders of his Fatherland in a tomb unmarked by date or name.

This wonderful man with a wonderful history was in one particular remarkably like other men. He made mistakes, numerous and sometimes serious mistakes. In another particular he was strangely unlike most other men. His mistakes were never forgiven, save at the mercy-seat of that Divine forgiveness in which he trusted.

How near this man's life comes to you and to me! It is almost a part of our own lives. Among civilized and enlightened people, wherever sickness is, there Hahnemann's influence is. There is not a “school” of medical practice in which it is not seen and felt and acknowledged. There is not an educated physician in all this land, however he may decry his doctrines, whose belief and practice are altogether free from the dictates of Hahnemann's teachings. He comes into our homes and teaches by our firesides, he ministers beside our beds of sickness, he cheers our sick chambers, he mitigates the pains and perils of disease, he wards away disaster. He restores the father to his business, the mother to her family, the man of affairs to his responsibilities, the child to the circling love of its parents' arms. How shall we recognize the worth of his inestimable ministry? Is Posterity doing this man justice? We shall never pay that old debt, repudiated a hundred years ago. But are we meeting our own obligations—the debt of the present? Let us at least trans-

mit to our children the heritage of healing we received through his self-denying labors. Let us extend the knowledge of his medical truth to those who have not heard it; publish his gospel of science in every household; rear and equip his colleges for the education of his physicians; swing wide on their hinges his hospital doors to welcome the sick and wounded poor; train his nurses for their angelic ministrations; pile high the altar-stones of loving memorial; tell it to the generations following; rear upon the everlasting granite his monument of imperishable bronze, to blazon forth that illustrious name, "Hahnemann," and herald the Divine promise of healing, "*Similia Similibus Curantur.*"

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### THE BICYCLE AS AN ELEMENT IN PHYSICAL CULTURE.

BY EDWIN H. VAN DEUSEN, M.D., PHILADELPHIA.

(Read before the Philadelphia Medical Club.)

THE bicycle needs no defence. It has won its way to the confidence of everybody who can afford it. Athletes of all grades and classes make free use of it for training purposes as well as for pleasure. There is a disposition, however, on the part of at least a few physicians of prominence and ability to condemn its use either in part or entirely. Over-exercise or misdirected exercise is just as bad in bicycling as in running, jumping, swimming or any other form of exercise, and no worse.

Bicycling exercises all parts of the body equilaterally. The perfect instinctive balance, which is the first thing to acquire in riding a bicycle, is impossible without perfect complementary action of the muscles of either side of the body. Indeed, this constitutes a perfect balance. Since this balance in riding is repeatedly being disturbed and regained, there must be repeated contraction and relaxation of the various sets of muscles concerned in maintaining the upright position. The constant jarring of the handle bar is a constant exercise to the hands and arms. Riders often experience more sense of weariness in the hands and wrists than in the legs, especially if the handles are not well adjusted. The legs, being the source of

the propelling power, do the greatest amount of work, and the extensor muscles of the thigh do as much work as all the other muscles combined.

The action of all the leg muscles is perfect in rhythm, and in ordinary road riding is never as violent or as long continued as in walking up stairs. The period of rest between the contractions is relatively long. In hill climbing it is possible in each revolution of the wheel for the period of contraction of the extensor muscles to equal in duration the period of relaxation. This is a mere possibility, and in practice rarely occurs. On down grades the movements are entirely passive. On a level road of good service a speed of from eight to ten miles an hour can be maintained by contractions and relaxations of the muscles, which at each turn of the wheel bear the relation to each other in point of time of probably one to five. That is, if the time occupied in the revolution of the pedals be divided into six parts, one of those intervals would be spent in work and the remaining five in resting; or, to speak more accurately, one would be spent in active motion and the remaining five in passive motion. The value of passive motion in muscle building and muscle rejuvenation has long been recognized. Self-massage has recently been highly extolled. No one seems to have conceived the idea of self-conducted, automatic passive motion on a broad scale, and yet this is what every wheelman practices from the moment he learns to ride without constraint. Movements of great amplitude, with the least amount of exertion, are practiced in moderate bicycling.

All riders notice the remarkable freedom from muscle soreness which attends bicycle exercise. After a prolonged rest, the first tennis game, the first baseball game, or the first run or jump is followed by stiffness and soreness of the muscles. Not so with bicycling. After a prolonged rest the rider may find himself soft and easily winded, but unless his riding is violent in the extreme he will not be sore the next day. The contractions and relaxations of the muscles most in use are steady, even and rhythmic. There can be no jerking and no sudden contractions. The whole machine acts as a balance-wheel to steady the muscle movements.

A few riders find no pleasure in the exercise. Fewer still find it positively irksome, and of course abandon it. The large

majority of wheelmen ride with a sense of exhilaration comparable only to that experienced by an accomplished horseman on his chosen steed off for a morning gallop. Perhaps bicycling is a preparation and a forecast of the sensations to be experienced when flying.

The number of riders and the amount of money spent for machines are indices of the interest taken in the exercise. There is a pleasure in riding the wheel born of the smoothness and swiftness and evenness of the motion. There is no angularity about it. All the turns are graceful, sweeping curves. The rush up a little grade and over the brow and down the incline makes one feel as a bird appears when, with a few vigorous motions of his wings, he lifts himself upward and then sails swiftly along with outstretched wings, motionless, in so far as any effort of his own is concerned.

The man who most needs exercise is the man who often is the least inclined to work of any kind. His interest must be enlisted. The bicyclist rarely needs to be coaxed to ride. Give him a good wheel, a fair road, and a spare hour or two, and he will not be long in deciding how to use them.

The posture of riders is almost as varied as the individuals themselves. Some riders sit bolt upright as if they were in straight-jackets, and in pedaling kick out behind like a duck swimming. Others set the saddle well back toward the axle of the rear wheel, and set the handle bar so low that the body is well-nigh horizontal. These, of course, are extremes which are to be avoided. Rapid riding demands a forward inclination of the body. It is as impossible to ride at a 2.80 gait sitting bolt upright, as it is to run a hundred yards in ten seconds without leaning forward. Riders who indulge in scorching find it impossible, with handle bar raised, to hold their own with their fellows; and since their pleasure is in speeding, they willingly submit to the inconvenience of having to lean on the handles when riding slowly in order to have the best position for riding fast. Much has been said and written about the harmfulness of this jack-knife posture. All the statements have been based on theory. There seem to be no statistics. There is no lack of material on which to base statistics, for every racing man in Class A, Class B or the professional class presents himself as an item. To all appearances racing men are

physically fine specimens of humanity. They are not stoop-shouldered. They do not seem to suffer from diseases of the heart, lungs or the digestive system. Their perineal tissues do not seem to sustain any considerable injury. They are often slightly proportionally over-developed in the legs, but not any more unequally developed than athletes in other branches of athletic sport. Although they habitually ride as completely doubled up as possible, they come out at the end of the season in as good physical condition as their most upright critics. One would think that a medical man studying physical culture, seeing every racing man in the country riding with handle bar low and seat set six inches back of the crank axle, would suppose this to be the position found by experience to give the best results for the attaining of a high speed with the least effort. But the average medical mind does not incline that way. He has always supposed that it was necessary to sit up straight, with head erect and chest forward, with shoulders back, etc., in order to give free expansion to the lungs. Now here is a posture which is directly opposite, and assumed during violent exercise too. It would seem that the heart's action must be interfered with; that the lungs cannot expand properly; that the riders must develop heart disease or consumption. But the riders go straight on riding and remaining in good health and every year increasing their speed. And the medical men go right on talking, some of them apparently even gaining speed.

It is easy to convince anybody who will ride a bicycle fast, that there is no doubt that the lungs are well expanded, no matter what posture is assumed. The heart's action also is probably not interfered with. The leg movements being alternate, the abdomen is simply kneaded and not really compressed. This kneading or massage is probably a benefit to the abdominal organs and not harmful to those of the thorax. The posture is not so cramped as in rowing, and very little more so than in rapid running. The fact that heart disease is not habitually developed in racing men in spite of the violence of the exercise, is conclusive. Probably the worst that can be truthfully said about the posture is that it is ungraceful, and in moderate riding unnecessary, and should therefore be avoided by those riders who are satisfied with a speed of not more than twelve miles an hour.

Bicycling for children of both sexes is an excellent exercise. Of course, over-exercise is not good. After the novelty has worn off, there is no more tendency in children to over-exercise in bicycle riding than in any other kind of exercise. The exercise itself is superior in that it aids digestion, improves the appetite, hastens the circulation in the lungs through the deeper and freer respiration, and in the abdomen and pelvis, as well as the legs, through the pumping of the blood by alternate rhythmic contraction and relaxation of the muscles. It cures and prevents constipation. It supplies more blood and better blood to all parts of the body. This is what promotes growth and development, and growth and development are the prime characteristics of a healthy childhood. Bicycle riding does not retard the growth of the leg bones nor warp them. The weight on them is at no time greater, and rarely as great, as in walking or running. There is never any jarring or pounding as there is at every step, and who on hygienic grounds would forbid a healthy child walking or running in moderation? The vertebræ are taxed no more than in any other exercise, and the muscles of the trunk are constantly but not violently in motion.

The bicycle enlarges a child's sphere of observation, and educates him in regard to his surroundings. He soon learns the use of tools and some simple principles of mechanical construction. He raises or lowers the saddle to suit himself. He adjusts the handle bar. He tightens the chain. He examines the cones or the balls, or adjusts the bearings. He is his own engineer. He soon learns to become not only independent, but self-dependent. He learns to know his own ability in controlling his machine, and he must exercise his own judgment in regard to when to go slowly and when to hasten in avoiding vehicles and other obstructions. His perceptions are heightened, his judgment is developed. He becomes confident and self-reliant. He soon also learns the rights of others and their equality with his own. Comparatively few riders are reckless or heedless, and fewer still are hoggish.

A rider in a collision is as likely to be injured as the other, and from self-interest alone a rider would avoid a collision where care could do it. Collisions almost always occur as the result of some unexpected move, not on the part of the rider, but of the other party. Occasionally, no doubt, the rider is

entirely to blame. Probably boys are more often knocked down in collisions when running than when riding, for the reason that a boy in running is often looking at the thing from which he is running, and as often does not see where he is going, while a boy riding sees where he goes. Barring accidents, which are no more frequent or serious than in other sports, the bicycle is a help to any boy. To a girl it is almost equal to a proclamation of emancipation. When she is a child she may run, jump, and play as boys do. When she becomes a girl in lengthened skirts she must stop romping and behave sedately. When she becomes a young lady, her only exercises for the greater part of the year are sweeping, sewing, washing the fine china and glassware, shopping, and dancing in a hot crowded room, encased in a garment which retains its integrity only on account of the excellence of the material. Occasionally she takes a walk, but more for companionship than exercise. If she has a wheel, there is a world of difference. She may ride as a child, a girl, a maiden budding or full blown, a wife, a mother—a grandmother, if she wish. She always rides in the open, unbreathed air, and no fashion has yet decreed that she must wear any but comfortable garments. She may wear a sweater, or a shirt waist fitted with a pair of balloons. She need not, and she should not, wear any garment that prevents freedom of motion. Fashion as well as common sense so declare.

The question of costume from her waist down is still unsettled, and is too abstruse for any man to tackle. She must work out this part of her salvation, and many of her friends, male and female, Christian, pagan, and soldiers in the Salvation Army, are trembling and fearful lest she should take to stepping into her clothes instead of disarranging her hair while donning them. It is possible that the bicycle may be of good service in demanding a sensible modification of a garment which takes six yards of a feather-bone reed to encompass. But our foremothers were just as foolish.

Bicycle riding in the matter of exercise does just the same thing for a woman that it does for a man. She has muscles that need exercise for development and renewal exactly as those of a man. She has lungs which are as much benefited by fresh, pure air as are those of a man. She has a circulation, upon

the character of which her tissues are as dependent as those of a man. She has a pelvis which is more ample, which contains more, and the circulatory demands of which are greater than is the case with a man. The bicycle is better suited to her needs than any other one agency, not excepting even a horse.

A recent writer on the subject, a man of course, made two statements, which, when placed together, seem incongruous, to say the least. Early in his paper he maintains that the bicycle is very unfit for women because it excites sexuality. At the close he objects to the bicycle for men because it destroys the sexual power. He cannot resist the temptation to remark that he is somewhat reconciled to the bicycle when he remembers that it is essentially an agency for the destruction of fools. To his mind the depopulation of the civilized world seems certain to result from the loss of life of many riders, and the loss of manhood in the remainder.

It is unwise to jest in print about such a subject, and yet it seems almost impossible that these statements could have been made in serious earnest. The question of bicycle eroticism in women is very difficult of investigation for obvious reasons. It is extremely improbable that it exists at all. Bicycle riding has the same effect upon the sexual function in men as any other athletic exercise. It produces a beneficent effect upon the excessive sexual desire fostered by high living and indolence, but does not in any degree destroy the procreating power. It is an antidote to licentiousness, but not a menace to the continued existence of the race. Indeed, it will improve the race by improving the health of the progenitors of the race.

It promotes sobriety. Bicycle riders may drink occasionally, but intoxication and riding a bicycle are utterly irreconcilable.

Bicycle riding exercises all of the body equilaterally. The movements are steady, rhythmic, and succeeded by a period of rest which always equals, and usually much exceeds in duration, the period of activity. Consequently there is little or no muscle soreness following moderate riding. It develops not only a child's limbs and lungs, but also his judgment, self-control and self-dependence. It cures indigestion and constipation, and all troubles resulting from retarded or perverted circulation. It is one of the best remedies for neurasthenia. It is as well adapted to the needs of women as of men. It has

one serious objection. It is so delightful, that at one time or other most riders succumb to the temptation to ride too far or too fast. For this reason a few words of warning to riders are necessary.

1. Except under unusual circumstances, do not ride at a speed which compels you to open your mouth for breath.
  2. Never be ashamed to walk a hill.
  3. If the hill is harder to ride than to walk, take it flat-footed unless there is need for haste.
  4. Rush short hills, and ride steadily on long hills, keeping the wheel moving with sufficient speed to get the benefit of the momentum.
  5. Do not continue the outward journey into the period of leg-weariness.
  6. It is all right to set either a time-limit or a distance-limit upon your ride, but wrong to set both.
  7. Take as good care of yourself after a ride as you would of your horse.
  8. Ride slowly at all crossings.
  9. Use your bell when necessary to signal your approach, and not as a warning to get out of your way.
  10. If you are not a lady, always be a gentleman.
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**PRINCIPLES OF THE APPLICATIONS OF SUTURES IN PLASTIC OPERATIONS—G. Walcher.**—Many operators do not obtain the results expected in plastic surgery where there are large surfaces to be united, as in the closure of the perineum or the abdominal wall after laparotomy. The fault may lie in placing the suture in a line parallel to and near the cut margin of the wound. A suture introduced in this way is like the running string of a tobacco pouch, and like it, when tied, puckers the surfaces together in a thin layer where a broad, firm line of union is desired to restore the parts to anything like the original condition. This can be obviated to a great extent by making the suture describe a circle to one side of the wound, the diameter of which shall equal the height of the wound. If no puckering of the wound is desired the half-circle of the ligature should be carried a little further and be made to dip down a little below the bottom and to one side of the wound and then to just come out at the lowest point of the sulcus or bottom of the incision, where it is once more introduced to correspond with the opposite side. A suture introduced in this manner has the outline of an inverted heart, the median inner angle of the inverted heart occupying the lower margin of the wound. It will be readily seen how drawing together this suture tends to spread the raw surfaces together into a broad line of union, as well as compressing them together in this position. The same principle can be used to advantage in suturing the abdominal wall. The point of the needle is first introduced almost parallel with the skin so as to obtain a good bite of muscle before it is turned and thrust down through the muscle and out at the peritoneal margin corresponding to the line of introduction to make a symmetrical loop.—*Ibid.*

THE TERM ABORTIVE TYPHOID FEVER IS A MISNOMER; IT IS INACCURATE AND INAPPLICABLE.

BY WILLIAM A. HAMAN, M.D., READING, PA.

THE instructive case of "Typhoid Fever and Some of its Lessons," by Dr. Searle, of Brooklyn, contained in the March HAHNEMANNIAN, is doubly interesting in demonstrating the efficacy of homœopathic medication in threatening pudendal noma, and in discussing the disputed subject of so-called abortive typhoid fever.

The article contains one statement with which I cannot agree, viz., "For myself, I must express the conviction that cases manifesting the distinctive and characteristic eruption of this disease never abort with or without treatment—at least, I never saw one thus distinguished that did not run *the well-known and classical course*, in spite of all that was done to stop it." (Italics are mine.)

I have seen a number of cases, in which I felt sure that genuine typhoid infection existed, that terminated, often abruptly, toward the close of the second week, aborted in the sense that the fever terminated prior to the end of the usual four weeks', or longer, fever.

It is to this interpretation of the term abortive typhoid fever that I object, because I have reason to believe that the developmental cycle of the infective germs in these cases has been completed, as in those cases that continue the remittent type of pyrexia two or more weeks longer.

February 19, 1894, a lady of 32 years, and two daughters, aged 14 and 11 years, were sent by me to the Homeopathic Hospital of Reading. They were afflicted with a continued fever that commenced almost simultaneously, characterized by diarrhoea, epistaxis, roseolous abdominal rash and prostration. The mother died of intestinal haemorrhage on the twentieth day of the disease. The older daughter died of peritonitis on the twelfth day, due to extension of the inflammation. In the younger daughter the temperature fell to normal on the fourteenth day, and remained so during her convalescence.

December 1, 1895, a mother, in the convalescent stage, and three children, two boys and one girl, in the active fever, were sent by me to the Homœopathic Hospital of Reading. The mother's convalescence being protracted, it was learned that an antecedent degeneration of the kidneys had undergone a serious aggravation; this ultimately caused her death.

The lads went through the ordinary four weeks' fever. The girl had a typical attack, roseolous rash, delirium, epistaxis, tumid abdomen, with moderately constipated bowels.

During the twelfth night her temperature, in two hours' time, dropped from 103° F. to 99.5° F. The nurse and resident physician were alarmed at the prospect of intestinal haemorrhage, and at once communicated with the attending physician. They were reassured by a corresponding drop in her pulse-rate. Her convalescence was uneventful, with the exception of a recrudescence of pyrexia of several days' duration, due to a visitor unwisely smuggling fruit into her possession.

These, I am sure, as it is possible to be confident of something undemonstrable, were examples of genuine typhoid infection that terminated *apparently* prematurely.

The italicized phrase in the excerpt from Dr. Searle's paper, *well-known and classical course*, indicates the source of the confusion surrounding this subject.

It is a fact more generally recognized now than formerly that no other specific fever more frequently presents itself atypically; in consequence, the less stress we lay upon the necessary presence and usual duration of typical signs of typhoid infection to complete the picture of typhoid fever, the fewer will be the mistakes in diagnosis.

We are apt to overlook the fact that there is but one essential lesion in typhoid infection, and, unfortunately, the presence of this lesion cannot be demonstrated *ante-mortem*, viz., inflammation (not necessarily ulceration) of the lymph follicles of Peyer's patches and solitary glands of the intestines.

The usual objective lesions of typhoid infection taken singly, when absent, have no negative value. What more common symptom of typhoid infection than pyrexia have we? Yet genuine sporadic and epidemic typhoid infections have existed

in which there never was any fever; typhoid infections have been met with in which no splenic enlargement could be made out; others in which no roseolous rash could be found.

Inconstant lesions surely cannot be accepted as criteria by which to judge of the success or non-success of infection.

If afebrile typhoid infections can exist (and they have been confirmed by autopsies), what is there singular, I ask, in the disappearance of the febrile movement toward the close of the second week, about the middle of the period that the majority of cases of febrile typhoid infections endure?

Typhoid infection generally results in a compound fever, with no appreciable interval between the primary fever, due to the effect of the various toxic ptomaine principles upon the solid and fluid tissues, and the secondary fever (a septic pyrexia—a sphaemia), due to the ulcerating and suppurating specific intestinal lesions.

The primary fever is exhausted in about fourteen days in severe cases, and somewhat earlier in milder cases.

Should the infecting virus be in a condition of attenuation, or the pabulum offered it by its host be unsuited to the production of the usual amount and variety of ptomaine principles, or the vital assistance of the lymphoid follicles to the disintegrating effects of these principles be increased, the inflammation and infiltration of Peyer's patches and solitary glands undergo resolution instead of sphacelation, and the febrile movement naturally comes to a termination, often abruptly.

This theory is strengthened by the change in the temperature curve in the third week of cases that present the secondary fever.

During the first week the fever is ingravescient, during the second week steady, with but comparatively slight remissions, while during the third week morning remissions become marked.

Variola is another acute zymosis in which the pyrexia is compound, but in which an appreciable interval exists between the primary and secondary fevers.

Varioloid, however, the same disease, presents only the primary fever, but the eruption being slight and septic absorp-

tion almost nil, the secondary or suppurative fever does not occur.

Varioloid bears the same relation to small-pox that so-called aborted typhoid fever bears to the typical classical fever. No one speaks of varioloid as aborted small-pox, but as small-pox in a form so mild that the usual secondary fever fails to materialize, or in so mild a form as to practically amount to nothing; it is modified by the human soil having been rendered unfit for the vigorous development of variolous germs by reason of vaccination or a previous attack of variola.

The question naturally hinges upon the meaning given the term abortion as applied to the results of inoculation of germs of infectious fevers. Of the various definitions given of the term abortion "to fail of development" is the one I think most suited to be used in this connection.

Known exposure and implantation of the germs of typhoid fever in persons who prove to be *immune* are examples of what to me seems an abortion in this connection.

Inoculation followed by progress through the developmental cycle of the germ, and the production of the essential lesion of the disease without ulceration, attested by demonstration in a few cases, and without the usual prolonged fever, prove the subject *refractory*, owing either to more vigorous tissue resistance or feeble production of ptomaine principles due to attenuation of virus or deficient pabulum; this latter cause, deficient pabulum, has its analogy in the well-known fact that plants generating alkaloidal principles when grown out of their natural soil produce these principles in smaller amounts.

These statements, I think, are reasonable and justify me in avoiding the use of the term abortive typhoid fever, for, according to my view, so-called abortive typhoid fever is as genuine a case of typhoid fever as one that lasts four months.

I heartily agree with Dr. Searle that typhoid fever cannot be cut short by treatment. If inoculation proves successful, and the development of germs commences, this progresses until completed. We can often curb the violence of the resulting disease, but it is folly to suppose that we can wield over its germ development the benign influence that we so frequently are able to wield over the development of the malarial parasite.

**A CASE OF POLYPI OF THE BLADDER—REMOVAL.**

BY FRITZ C. ASKENSTEDT, M.D., BRYANTSVILLE, KY.

(Read before the Kentucky Homeopathic Medical Association, May 20, 1896.)

A POLYPUS of the bladder usually proves so distressing to the patient and perplexing to the physician that any measure, short of a cystotomy, that promises permanent relief is readily embraced by both. The invariable benefit all cases of subacute cystitis receive from Porter's dry-heat treatment when properly applied is not generally recognized by the profession, and to illustrate how it may pave the way, by dissipating local congestion and tenderness, for a more radical treatment of polypi of the bladder, the following case is submitted for discussion:

On February 7, 1894, I was called to see Mrs. N., æt. 50, mother of two children of twenty-one and twenty-three years respectively. Excepting a dysmenorrhœa, from which she had suffered ever since the catamenia first appeared, the patient's health had always been good until fourteen years ago, when symptoms of acute cystitis set in from some unknown cause. With the exception of an amelioration in 1890, lasting about six months, the symptoms had continued unabated, compelling her to assume the recumbent position most of her time. Several physicians had been in attendance successively; but no local treatment had been instituted.

At the time of my first visit she complained of frequent micturition, sometimes having to arise fifteen to twenty times during the night, each act being followed by great pain and strangury, even for a time after returning to her bed. The bowels were constipated, moving once in five or six days, and the evacuations were usually painful. The appetite was poor, and the sleep, of course, was much disturbed. There was an eczematous eruption scattered over the abdomen, arms and legs, and she complained of frequent headaches, with nausea and vomiting, blurred and double vision. There was no evidence of syphilis. It is needless to say that she was very despondent, wishing that death would soon end her suffering. On

physical examination I found a retroflexion of the uterus, some endocervicitis, a profuse leucorrhœa, some tenderness over the bladder; but no inflammation of the meatus urinarius, the vulva or vagina. The uterus was replaced, and, two days later, a Smith pessary introduced. Aided by indicated remedies, principally *sepia*, *nux vom.* and *sulphur*, the bowels gradually became regular; the eruption disappeared, headache became less frequent and intense, and appetite returned. But the bladder symptoms, which I thought might be secondary to the uterine displacement, were but slightly improved. Since strength and hope were rapidly returning to the patient, I directed her to apply to my office, as soon as able, for treatment with "dry heat."

On April 2d, eight weeks after my first visit, the patient entered the office much exhausted by the ride and sitting posture maintained. Porter's "vesico-uterine heater" was used, and the treatment repeated every three or four days. The bladder symptoms improved uninterruptedly until May 23d, when the patient felt so much better that she discontinued the treatment. While withdrawing the urine, previous to introducing the heater, I had always felt a slight tapping sensation on the catheter just before the last of the urine escaped, and since, in the beginning of the treatment, small flocculent shreds of blood were found floating in the urine—but careful bimanual manipulation failed to reveal a tumor, and no hard body could be detected by the heater—I suspected the existence of a polypus. The soreness of the bladder became so reduced that a well-defined point of tenderness, somewhat less than a twenty-five-cent piece, could be definitely located near the fundus, a little to the left of the median line. I proposed to remove the neoplasm with the cold snare; but as the case was progressing very satisfactorily to the patient, she was unwilling to submit to any other treatment.

After discontinuing the treatment, however, the pain and strangury gradually returned, and on September 8th she came back for anything that promised permanent relief. The tenderness having again become diffused, I decided to resume the treatment with "dry heat" until the congestion was reduced as far as possible. On the 23d of October I considered her ready for the removal of the polypus, the tenderness still remaining

at the indicated location in the bladder and some strangury after urinating continuing. After evacuating the bladder with a catheter and injecting about six ounces of sterilized water, a Bosworth snare was inserted through the urethra over the painful area and withdrawn. No perceptible resistance being felt on retracting the wire into the canula, the operation was repeated twice to insure against failure. The patient was then instructed to remain quietly in bed for a few days. One week later she entered my office to report that she was now well. She stated that for two days after the operation she suffered greatly from strangury and pain, even producing nausea and vomiting, until she passed two pieces of flesh while urinating. These pieces she described as being whitish bodies, each about the size of a small bean, with a bloody speck on only one side of each. Instead of one polypus, as I at first supposed, I was led by this description to infer that there must have been two in close proximity. Since this time she has remained entirely free from her vesical trouble, and said a few weeks ago, eighteen months after the operation, that she was enjoying as good health as ever.

Here we have a case of cystitis of fourteen years' standing, perpetuated, no doubt, by the pain and irritation of the new growths, where internal remedies failed, and where few of us would hope to accomplish much with injections of nitrate of silver or other astringents. The difficulty of locating the site of a polypus in the bladder when in a state of marked irritation would render every effort at applying the wire to the polypi at least uncertain, if not dangerous. Under the ordinary methods the only promise of relief to the patient would be a cystotomy, with its attendant risks. With the "dry heat" treatment the removal of the neoplasms becomes safe, certain and, what is essential to all our surgical procedures, acceptable to the patient. Consequently I feel that Dr. Porter's heaters merit a greater attention from the profession than they have hitherto received, and while they are more especially designed for gynaecological practice, when judiciously applied they will prove valuable adjuvants to the usual treatment of all inflammations of the bladder and rectum, and occasionally, as in the case just related, an aid to diagnosis and surgery of the organs.

## HAHNEMANNIANA, No. 4.

BY THOMAS LINDSLEY BRADFORD, M.D., PHILADELPHIA.

THE picture presented this month is of the first wife of Hahnemann; the wife of his youth, of his wander-years, who assisted him in his struggles, patiently bearing with him the burdens of poverty and privation, taking from his shoulders the petty vexations of domestic worry, so that the reformer might give an undivided mind to his studies and translations. Johanna Henrietta Leopoldine Küchler was 19 years of age when the young physician, Hahnemann, aged 28, married her. He had gone to Dessau to practice in the spring of 1781, and was in the habit of frequenting the laboratory of the apothecary Haseler, who had succeeded in business the apothecary Küchler and married his widow. Hahnemann, in his autobiography, says: "Now I began to taste for the first time the innocent joys of home along with the delights of business in the companionship of the partner of my life, who was the step-daughter of Herr Haseler, an apothecary of Dessau." The registry of the church of St. John in Dessau bears the following inscription: "On the 1st of December, 1782, Herr Samuel Hahnemann, Dr. med., Electoral Saxon Parish doctor in Gommern, 28 years old, eldest legitimate son of Herr Christian Gottfried Hahnemann, artistic painter in the porcelain manufactory of Meissen, and of his wife, Johanna Christiana, was married to spinster Johanna Henrietta Leopoldine Küchler, 19 years old, only legitimate daughter of the late Godfried Henry Küchler, and of his wife, Martha Sophia, in St. John's Church here."

For forty-eight years this brave woman shared with Hahnemann his adversities; she died at Coethen on March 31, 1830, aged 67 years. Albrecht, who knew her well and who was intimate with the family, says of her: "She was a remarkable woman, of an energetic character and educated above the ordinary standard. She was much beloved and respected by her husband and children. She had a musical education, and composed words to music written by herself. Hahnemann was a great lover of music and had a pleasant singing voice, but



FRAU HOFRATH JOHANNE HENRIETTE LEOPOLDINE HAHNEMANN, GEB. KÜCHLER.



without knowing a note. He was fond of coming into the parlor when he took an interval of repose from his work, between nine and ten, and of getting his wife to play something on the piano." There has been considerable written about the unpleasant temper of Frau Hahnemann. She has been called even a Xantippe, and it has been written that Hahnemann's life was very unhappy with her. There is nothing in the accounts of the domestic life of the master that substantiates such a calumny. Hahnemann ever spake with love and respect of the helpmate of his youth, his beloved "Elise."

And the wandering life led for some years, the times of poverty when Hahnemann gave up practice entirely rather than use the old methods in which he disbelieved, the makeshifts for existence with a growing family, all these were not calculated to foster a spirit of sweetness and urbanity. Frau Hahnemann stood often between the scholar and the trials of his life; she saved him when possible; she was the housewife, the manager, and it is likely was somewhat dictatorial. But she was well beloved to the last.

Hahnemann, in a letter written shortly after her death, mentions rising from his own sick bed to visit her, concealing his own illness from her for fear of giving her pain. A French biography of Hahnemann was published about 1862, in which the first wife was mentioned as unamiable and not understanding her distinguished husband; it was claimed by the daughters of Hahnemann that this article was prompted, if not written, by the second wife. It is said by the daughters that Frau Hahnemann was possessed of property which she sacrificed to assist Hahnemann. One of Hahnemann's daughters says: "Johanne Leopoldine sacrificed to him her whole property when he formed the great-souled resolution of withdrawing altogether into the sanctuary of his creative mind, in order to devise means and ways to relieve mankind from the bodily sufferings afflicting it, after he had recognized the existing methods, though a thousand years old, still not only insufficient, but as causing unceasing new corruptions. That the thoughtful housewife, the faithful mother, often must have been full of anxiety when she considered what would become of her numerous family if Hahnemann should not satisfactorily solve the difficult problem—who would wonder at this?" This

mother was dearly beloved by her daughters, and when the small statue to Hahnemann was unveiled in Coethen by Lutze, in 1855, the daughters dedicated and sang a poem to the memory of that mother, the music and words of which were composed by themselves. In one place we find Hahnemann saying to his wife after he had found refuge at Coethen from his troubles: "Yes, mother, that is true, how could I have helped succumbing to the manifold persecutions which have passed over me without your support? How could I have been able to pass with such courage and such strength through the storms of life which drove us through half the world, if you had not so friendly stood at my side?" In a letter written to the wife of his young manhood he writes: "I praise thee not, I only know thee! admire thee not, only love thee! and willst thou believe me—so calmly, so judiciously, that I am satisfied that after many years, if possible, that I shall feel still more for thee, if the closest of all happy ties can be enduringly interwoven by Providence. Let us then, Elise, entwined in each other's love, seize the happy moments and string them as pearls on our common thread of life."

The testimony of the scholars of Hahnemann who were constantly in the household during the days at Leipsic is that Frau Hahnemann was a great-hearted, noble woman.

The picture from which this is taken was published in the *Leipziger Populaire Zeitschrift* for July 1, 1893.

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#### TOTAL SOLIDS IN URINE: CALCULATION AND DIAGNOSTIC APPLICATIONS.\*

BY CLIFFORD MITCHELL, M.D., CHICAGO.

By the term total solids in urine we mean the weight of all the normal solids dissolved in it. We do not include in this category abnormal constituents, as albumin, sugar, bile, blood, etc.

The most important normal solids are urea, common salt, the sulphates, phosphates, urates, kreatinine, and hippuric acid, the average quantity of which per 24 hours is shown in the following table:

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\* Advance sheets from the writer's forthcoming book on Urinary Analysis.

TABLE I,

Constituent.	Average Amount in 24 Hours.				
Water, . . . . .	40 to 50 fluid ounces, 1200 to 1500 c.c.				
Urea, . . . . .	310 to 615 grains, 20.0 to 40.0 grammes.				
Urates, . . . . .	6 "	12 "	0.4 "	0.8 "	"
Hippuric acid, . . . . .	8 "	15 "	0.5 "	1.0 "	"
Kreatinine, . . . . .	8 "	20 "	0.5 "	1.3 "	"
Chlorides, . . . . .	155 "	245 "	10.0 "	16.0 "	"
Earthy phosphates, . . . . .	15 "	23 "	1.0 "	1.5 "	"
Alkaline " . . . . .	30 "	60 "	2.0 "	4.0 "	"
Sulphates, . . . . .	45 "	60 "	3.0 "	4.0 "	"

The sum total of these various solids in the urine of a healthy adult male, weighing about 150 pounds, on ordinary mixed diet, and taking ordinary exercise, may be expressed as follows:

Urea, . . . . .	500 grains.
Common salt, . . . . .	250 "
Other solids, . . . . .	250 "
Total solids, . . . . .	1000 "

That is, urea represents about half the total solids and common salt about one-quarter.

In my opinion these figures are maximum ones, and much lower results may be obtained by analysis in the case of perfectly healthy persons under certain circumstances of age, diet, and exercise, as will be shown further on.

The weight of the total solids in urine, which chemists obtain by evaporating the liquid to dryness and weighing the solid residue, may, for clinical purposes, be computed mathematically as follows:

1. Take the specific gravity of the 24 hours' mixed urine.
2. Multiply the last two figures of the specific gravity by 2.33 (Haeser's coefficient).
3. Divide the product by 1000.
4. The quotient obtained is *grammes* of solid matter in the 24 hours' urine. To convert into *grains*, further multiply by 15 $\frac{1}{2}$ .

Now, in taking the specific gravity of the urine two precautions must be observed: First, the urinometer must be fairly accurate; second, the specific gravity must be taken at the temperature at which the urinometer is standardized.

There are two kinds of urinometers, fairly accurate ones, and decidedly inaccurate ones. Those made by Squibb, sold by Eimer and Amend, New York, are recommended as being accurate; but, unfortunately, a number of imitation urinometers bearing Squibb's name are on the market. I know from experience that if thirty or forty urinometers marked "E. R. Squibb" are successively floated in the same urine at the same temperature, the readings will vary very considerably. Furthermore, there are still other urinometers made, tested, and "certified" which will in turn give a different set of readings, in the same sample of urine, from those marked "E. R. Squibb." I have known these variations in urines of high specific gravity, 1030 or upwards, to be as great as 8 or 10 degrees. I think it worth while, therefore, to buy the Squibb outfit of urinometer, thermometer, and fluted jar. Pour a sample of the 24 hours' urine into the fluted jar; set the latter in a glass of warm water; take the temperature of the urine with the thermometer; and, when it is 77° F., remove the fluted jar from the warm water and take the specific gravity at once.

I have not been able to draw any deductions whatever from the old-fashioned method of comparing the total solids estimated, as above, with some arbitrary normal average, as 58 grammes. When we know nothing about the patient, as is sometimes the case, we may indeed guess at the amount of "renal insufficiency" by comparing the solids computed as above with 58 grammes (900 grains). But when the age, weight, diet, and exercise of the patient are known, our ideas of the relation of solids excreted by him to what work his kidneys ought to do are much better. For example, take the following: 24 hours' urine, 900 cubic centimeters (30 fluid-ounces); specific gravity, 1015. Total solids, 15 times  $2\frac{1}{2}$  times 900 divided by 1000 equals  $31\frac{1}{2}$  grammes or 488 grains. Suppose the patient's condition be unknown. We would say, in a general way, that his kidneys were doing only half the work they ought to, since 488 is about half of 900 to 1000 grains, which we assume the normal excretion to be. But suppose the patient was above 70 years of age, or, if between 20 and 40, weighed only 100 pounds, and was in bed on restricted diet? It stands to reason that in either of these cases we might be seriously at fault in assuming renal insufficiency. In

order to make deductions of any definite value, says Dr. Purdy, from the actual quantity of solids found, careful regard must be paid to certain conditions and features connected with each individual case, the most prominent of which are the weight, age, diet, and amount of exercise taken. Purdy's rules for making reduction or addition for weight, age, diet, and exercise involve considerable figuring; so I have constructed a table, based on his rules, giving reductions or additions for weight and age at a glance.

The normal average excretion of solids for a person between 20 and 40 years of age, weighing 145 pounds, on ordinary mixed diet and taking ordinary exercise, is assumed to be 945 grains (61.14 grammes). On this assumption\* the following table is constructed:

**TABLE II.†—Normal Averages of Total Solids in the Urine of Persons on Ordinary Diet, Taking Ordinary Exercise.**

WEIGHT.	NORMAL EXCRETION.				
	Age 20 to 40.	Age 40 to 50.	Age 50 to 60.	Age 60 to 70.	Age above 70.
145 pounds.	61 gms., 945 grs.	55 gms., 850 grs.	48 gms., 756 grs.	42 gms., 640 grs.	30 gms., 473 grs.
140 "	912 "	820 "	780 "	634 "	450 "
135 "	878 "	790 "	702 "	608 "	439 "
130 "	845 "	760 "	675 "	582 "	428 "
125 "	812 "	730 "	649 "	556 "	406 "
120 "	789 "	702 "	624 "	580 "	390 "
115 "	748 "	678 "	598 "	504 "	374 "
110 "	715 "	644 "	572 "	478 "	357 "
105 "	682 "	614 "	545 "	432 "	341 "
100 "	650 "	585 "	520 "	428 "	325 "
95 "	618 "	556 "	494 "	400 "	309 "
90 "	586 "	526 "	468 "	374 "	293 "
85 "	552 "	497 "	442 "	348 "	276 "
80 "	520 "	468 "	416 "	322 "	260 "
75 "	488 "	439 "	390 "	296 "	244 "
70 "	456 "	410 "	365 "	270 "	228 "
For weights above 145 pounds (66 kilograms).					
150 "	978 "	880 "	782 "	685 "	489 "
155 "	1010 "	910 "	808 "	707 "	505 "
160 "	1042 "	988 "	833 "	729 "	521 "
165 "	1074 "	967 "	859 "	751 "	536 "
170 "	1106 "	998 "	885 "	778 "	553 "
175 "	1138 "	1024 "	910 "	795 "	569 "
180 "	1170 "	1068 "	936 "	817 "	585 "
185 "	1202 "	1082 "	962 "	840 "	601 "
190 "	1234 "	1110 "	988 "	862 "	617 "
195 "	1266 "	1140 "	1014 "	884 "	638 "
200 "	1298 "	1168 "	1040 "	907 "	649 "
205 "	1330 "	1197 "	1066 "	930 "	665 "
210 "	1362 "	1226 "	1092 "	952 "	681 "
215 "	1394 "	1255 "	1118 "	973 "	697 "
220 "	1426 "	1284 "	1144 "	995 "	718 "
225 "	1458 "	1312 "	1170 "	1020 "	729 "

\* The mean of the combined observations of eight writers.

† From the writer's book on *Urinary Analysis*.

The preceding table gives corrections for age and weight only. From these figures deduct 33 per cent. for fasting two or more days, as in some fevers, or 12 to 16 per cent. for a sparing diet, or 10 per cent. when the person is not eating as freely as when in health.

*Furthermore*, deduct 10 per cent. if the person is in bed, or 5 per cent. if confined merely to the house.

Examples illustrating the above:

1. Solids computed, 530 grains in the 24 hours' urine.

Patient 35 years old; weight, 155 pounds; diet, ordinary; exercise, ordinary.

*Deduction.*—A person 35 years old, weighing 155 pounds, should excrete (Table II.), on ordinary diet and exercise, 1010 grains. The person in question excretes 530 grains. Therefore he or she is passing only about half what should be excreted in 24 hours.

2. Solids computed, 530 grains in 24 hours' urine. Patient 65 years old, weighs 140 pounds, eats sparingly, and is confined to the house.

*Deduction.*—A person 65 years old, weighing 140 pounds, should pass (by Table II.) 638 grains of solids when on ordinary diet and exercise. But as the diet is sparing, deduct from 12 to 16 per cent. of 638, say 90 grains; 638 — 90 equals 548 grains. Still further, deduct 5 per cent. from the figure last obtained since patient is confined to the house. Five per cent. of 548 is about 28 grains. Final figure, 548 — 28, or 520 grains. In other words, a person under these circumstances should void about 520 grains of solids in 24 hours. The amount computed is 530 grains. Therefore, he or she is passing just about what would be expected under the conditions.

It stands to reason that a faulty urinometer will cause considerable difference in results:

Example 3.—Urine in 24 hours, 1000 c.c. (33 fl. ozs.); specific gravity by one urinometer, 1080; by another, 1022.

Patient weighs 175 pounds; age, 80; diet, hearty; exercise, vigorous. By one urinometer, the first, he is voiding 70 grammes (30 times  $2\frac{1}{2}$  times 1000, divided by 1000), or 1085 grains. By the second instrument he is voiding 51 grammes, or 890 grains. A person of his age, weight, etc., should void at least 1138 grains (Table II.). If the first urinometer is

correct, he is voiding only about 50 grains short of what we should expect. If the second urinometer is correct, he is voiding 250 grains less than he ought; 890 grains would represent the excretion of a person weighing 40 pounds less than the person in question.

The whole calculation, with the table and reductions, depends greatly on the accuracy of the urinometer used.

Lastly, if the urine contains any sugar or albumin in abundance the method of computing solids is not trustworthy, since the specific gravity of the urine is changed by the abnormal constituent present. Also in cases where there is considerable polyuria an inaccurate urinometer will give rise to a considerable error in results. For example, suppose the total quantity of urine in 24 hours be 2800 c.c., or 93 fluidounces. Suppose the true specific gravity at 77° F. be 1006. In this case the total solids are 6 times 2.83 times 2800, divided by 1000, equals 39 grammes, or 600 grains. But a urinometer giving a reading of 1008 would indicate total solids amounting to 52 grammes, or 800 grains, the error amounting to 200 grains.

When there is no great polyuria the total solids may be computed from saccharine urine by first fermenting with yeast, then filtering, and taking specific gravity at 77° F.

#### PRACTICAL APPLICATIONS TO DIAGNOSIS AND TREATMENT.

1. In gynecological cases and nervous diseases Dr. N. B. Delamater has shown for fifteen years past that deficiency in solids, with accompanying symptoms, often yields to eliminative treatment.

2. Dr. J. H. Etheridge has, independently, confirmed the statements so often made by Dr. Delamater showing, in a recent paper (*Amer. Obst. and Gyn. Journal*, June, 1895), that amenorrhœas, neuralgias, pelvic peritonitis, dyspepsias, bronchitis, cutaneous eruptions, headaches, backaches, leucorrhœas, nervousness, and insomnias accompany deficient excretion of urinary solids. Women passing not to exceed 400 grains of solids daily present various degrees of nervous irritability. When less than 300 grains are passed the condition of nervousness becomes serious; bronchitis, neuralgia, perimetritis or pleurisy may then result from taking cold. A very close relation exists between renal insufficiency and pelvic disorders.

Many of them are relieved by including in the treatment remedies that increase the urinary solids.

3. Deficiency in solids in the urine of men I have found to indicate unrecognized interstitial nephritis in some cases; in others, serious nervous disorders. Purdy says the same thing so far as the renal condition is concerned. In such cases collect the 24 hours' urine, day and night separately, determine urea and phosphoric acid, look for casts, and examine the patient's chest for cardiac lesions.

4. The differential diagnosis between diabetes insipidus and simple hydruria may be made by determining the total solids, which in the former disease are largely in excess of the normal average.

5. In fevers and acute diseases, as pneumonia and typhoid fever, the severity of the disease is indicated by increased quantity of solids in the urine; if, on the other hand, the temperature is high, but the excretion of solids in the urine is deficient, eliminative treatment should be employed, since elimination is evidently defective.

6. In diseases in which there is exudation, marked increase in the quantity of solids in the urine is a good sign, and indicates that eliminative treatment is not needed.

7. By subtracting the total urea determined in the 24 hours' urine from the total solids computed, an idea may be had as to the general composition of the urine in question. In cases in which the total urea is greater than three times the total salts (difference between total solids and total urea) I have observed great mortality.

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MORBUS BASEDOWII.—Dr. Peltesohn recently presented two cases of Basedow's disease before the Hamburg Medical Society. The one was a woman who came to him on account of the peculiar appearance of her face, which her friends had noticed. She only presented minor symptoms, such as a greatly accelerated pulse, 120-160, Graefe's and Stellwag's signs, tremor of the hands when the arms were extended, and flushes of heat over the face. This was, therefore, a masked form. The second was a woman who had had her eyes fitted for glasses a year before. In October, 1895, she suddenly was taken sick with great emaciation, rigors, and a typical symptom-picture of Basedow's disease. Peculiarly enough, a chronic iritis preceeded the outbreak of the disease for several months.—*Deutsche Medicinische Wochenschrift*, No. 10, 1896. [A singular variety of this disease is the acute form. Here the patient, after slight protrusion of the eyeballs for some time, may be suddenly seized by intense vomiting, diarrhoea, rapid action of the heart and great throbbing of the arteries. The eyes are large and staring, and the thyroid gland will be found much enlarged and soft. The gastro-intestinal symptoms may continue, the pulse become more rapid, the vomiting incessant, and the patient die in a few days.—Eds.]

## EDITORIAL.

### THE AMERICAN INSTITUTE OF HOMOEOPATHY.

THE Detroit meeting, while not the largest the Institute has held, was certainly one of the most successful, and reflects great credit upon all engaged, especially upon the officers and the local committee of Detroit, whose indefatigable efforts were highly appreciated by those in attendance. The executive office was filled in a manner satisfactory to every member, and the appointments for 1897, being based on merit and service, were acceptable. It is becoming apparent, however, that the president-elect should select his own cabinet or corps of workers, committee members and section chairmen, and not the retiring president, who is no longer responsible. The section work also needs remodelling. The habit of sections presenting twelve to fifteen different papers, some of them wearisomely long, should be stopped, and as a substitute each section should present three, or at most four, papers, taking fifteen or twenty minutes to deliver, on a carefully selected subject or subjects, the balance of the members of the section familiarizing themselves with the contents of the essays and preparing a well-thought-out discussion of the same, and in this manner do away with hurriedly read and presented treatises and choked discussions, or, what is worse, none at all.

Fortunately for the future of the Institute, offensive politics is a thing of the past, and the graceful withdrawal of Dr. MacLachlan of his nomination paper gave Dr. Custis an unopposed field, an honor highly appreciated by himself and all his friends. The necessity of designating a first and second vice-president in nomination papers, as pointed out by President Dudley two years ago, was much in evidence at this meeting, and a resolution was carried to that effect.

The Australian system of ballot was tried for the first time at the Detroit meeting of the Institute, and scored a decided success, the members all feeling that this election gave expression to the real sentiment and feeling of the Institute in regard to its future officers. Each name put in nomination

received the recommendation of ten members in good standing over their written signatures.

The referring of a place of meeting to a committee of five members, appointed by the President at the first session of the Institute, will be a wise innovation for 1897, and the mistake of having the Institute meet two years in succession at points so close together as Detroit and Buffalo will not be repeated. Precaution should also be taken to see that the voting in open meeting for a location be done only by members in good standing, and that ballots thrown in by those who are not members be rigidly excluded. Such ballots were cast this year, but the vote was so overwhelmingly in favor of Buffalo that the two or three votes so cast could not possibly have affected the result. The members present wanted Buffalo, and there the meeting will be held. It was unquestionably the desire of the vast majority of the members present to adopt a resolution, without debate, endorsing the efforts of the Michigan physicians to remove the homœopathic school from Ann Arbor to Detroit, and the wish was universally expressed that success would soon be the reward of their labors.

The Hahnemann Monument Report showed that President Cleveland had, for some unknown reason, declined to sign the bill passed almost unanimously by both houses of Congress, granting a site in Washington for the monument and appropriating \$4000 to build the foundation. It also emphasizes the fact that old subscriptions should be paid at once and new ones be secured in the near future. Only \$30,000 had been pledged, of which \$2000 had been collected, and that \$50,000 was needed to complete the work. The physicians have done their portion, and Dr. Orme's well-supported suggestion that a united appeal be made to the wealthy patrons of homœopathy ought to be adopted. The International Congress was given some attention, and the prevailing sentiment was that notwithstanding its shortcomings and lack of proper organization, and its worst of all blunders—the change of date—members of the Institute and of the profession generally who were going to be in Europe this summer should endeavor to rearrange their itineraries to suit the change of date. If this is done, America will have 100 to 150 representatives present, but in many cases it will be utterly impossible to alter their previously well-laid

plans to be in London in July, 1897, so those who can get to the place of meeting in August should do so, no matter what the personal inconvenience may be.

The Hahnemann oration by President Dudley was a noble effort and the centennial addresses by Drs. Jones, Van Denburg and Sutherland were masterpieces greatly enjoyed by the members present.

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#### A MEDICAL FALLACY.

We all remember Charles Lamb's *Essays on Popular Fallacies*. With what a delicate touch he playfully tilted off the halo of traditional veneration from some of the most widely accepted proverbs, and showed them up in their hollowness and hypocritical barrenness. With what heartfelt sympathy we heard him declaim against the cold-blooded advice that we should rise with the lark, and declare that "the good hours of the dawn were too sacred to waste as the sun's courtiers, attending his morning levees." With what admiration we applauded the courage of him who could assail what he calls the "cold-scrag-of-mutton sophism" of the saying that enough is as good as a feast.

Oh, that we had but a lamb here to gambol over our verdant medical field, and nibble at the medical fallacies which everywhere present such toothsome subjects for the sharp bite of his fanciful humor.

Few of the medical fallacies have crystallized into proverbs peculiar to medicine, but go about either clothed not at all, or borrowing the garb of some trite popular saw whereby they may hope to gain wider credence. Of this latter character is the fallacy found very widely diffused throughout the medical profession, that "What is sauce for the goose is sauce for the gander."

As to the true and original meaning of this proverb we would not wish to hazard an opinion. Whether it refers solely to an impartiality in dealing out rewards and punishments, or to a similarity in the condimental accessories necessary to render both male and female anseridæ palatable, is for our present purpose immaterial, since in either case it means that the treat-

ment adapted to one is equally adapted to the other, be it punitive or culinary.

The medical fallacy that we find concealed under this homely garb is that the effect which anything may have upon the physician, is to be taken as the standard according to which he is to judge of its effect upon others, and according to which he is to decide a thing to be hurtful or beneficial. He who likes not bananas condemns that nutritious and wholesome fruit because, perchance, at one time or another, it made its presence felt in him longer than the normal period of digestion justified. The warlike but luscious pineapple, whose juice aids digestion and melts diphtheritic membrane, will meet but sorry justice at the hands of the medical judge whose gastric capabilities have once been unduly taxed by an over-dose perhaps of this delicious fruit.

Not only in gastronomics is the prevalence of this fallacy apparent, but we find many using the same petty restricted standard in judging of other conditions and influences, regarding their own feelings as the criteria according to which these are to be valued. Perhaps in no one direction is this more evident than in the opinions held on the subject of athletics and physical culture in general, and of bicycle riding in particular. The skilful straddler leads on, he thinks, to health and happiness, regardless of orchitis, prostatitis, Scythian prototypes, hardened perinea, etc., while the timid walker, with an eye sharper than the X ray, sees all these things through every bicycle suit, be it never so "nobby" or "fetching."

As a modification of this fallacy is to be viewed, also, the hasty generalizations which so frequently retard the progress of science. A method of treatment, hygienic or medicinal, found efficacious for the goose is at once applied to the gander, and it is not until the latter proves refractory that the truth of the guiding principle begins to be doubted. Too often, alas, in an unjustifiable fit of impatience the sauce is thrown out, and neither goose nor gander gets the benefit of it.

To us homœopaths the goose-and-gander fallacy should be particularly repugnant, since to us individualization of remedies and of patients should be both our highest duty and our greatest glory.

Not only this, but the logical aim of our science must be the

individualizing also of environment. Thus, finally having secured our material, we will be able to proceed to generalizations for which we are not yet prepared. Every reported case should have given it all the individuality possible, both for the sake of full recognition and for future comparison. We know that all this is being done here and there, time and again, but in view of the rabid enthusiasm in the line of serum-therapy, of the antitoxine treatment of diphtheria, etc., noticeable in some quarters, we thought it would not come amiss to remind ourselves, that what is sauce for the goose is not always and necessarily sauce for the gander.

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#### TIT FOR TAT.

We are pleased to learn of the latest action of the Medical Council of Pennsylvania. It has rescinded its rule accepting licenses from the New York State Board of Medical Examiners since the New York Examiners refuse to accept licenses issued by the Pennsylvania Council.

Two months ago we strongly advocated reciprocity, and while this is, it is true, a sort of negative reciprocity, it is decidedly better than none, and we trust it may be extended to all branches of the subject. Let the merry war go on until the immature and illogical character of this whole examination movement has made itself evident, as well as the folly of attempting to transplant, full grown, to American soil a growth which is the result of ages of preparation in monarchical Europe, and which, at best, is foreign to the original spirit of our institutions.

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**AN ERUPTION FROM THE IODIDE OF POTASH.**—Dr. Du Castel recently showed a patient before the French Society of Dermatology and Syphiligraphy who, an old syphilitic, after having taken the iodide of potash, had appear upon his hands, forearms and face, an eruption beginning as erythematous patches, which were followed by bullæ filled with serum; these developed into phlyctenes surrounded by reddish zones. On the hands where they had opened they had become vegetating and papillomatous. He had taken the drug several times before without any untoward results. His kidneys were normal. Dr. Hallopeau remarked that at one time iodine will affect a patient and at another not do so. He has seen a patient become blind from iodo-potassic bullæ developing on the cornea. These tumors of the skin after poisoning by the iodide of potash may simulate those of mycosis.—*La Semaine Médicale*, No. 20, 1896. [Dr. Briquet, "De l'Iodisme; Variétés, Etiologie et Traitement," *Le Semaine Médicale*, No. 18, 1896, states that the iodides may give rise to any form of an eruption except the squamous.—Eds.]

## GLEANINGS.

### GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D., AND FRANK H. PRITCHARD, M.D.

**A CASE OF ACUTE PANCREATITIS.**—Prof. R. Sievers, of Helsingfors, Finland, records the interesting case of a man of 31 years, who previously well, if one except a typhilitis of eight years before and later dyspeptic attacks and slight diarrhoeic attacks, was suddenly seized with vomiting and painful distension of the abdomen. These symptoms continued for several days unchanged and without effect from any rectal injections of water. On the third day he had several scanty stools. On his entrance into the hospital he presented slight icterus, temperature  $31.4^{\circ}$  ( $100^{\circ}$ ) in the morning and  $37.7^{\circ}$  ( $99^{\circ}$ ) in the evening. His pulse was small, regular, 109. His mind was clear and he complained only of vomiting and tension in his abdomen. His respiration was rapid and difficult. Lungs and heart normal. His abdomen was enormously distended, yielded a very sonorous and tympanitic sound, with slight dulness in both flanks; no exudate nor sensitiveness to pressure.

Without any apparent change this condition persisted for fourteen days, when he died. The necropsy revealed all through the abdominal fat numerous yellowish-white spots of the size of a lentil to that of a pea which on section were seen to consist of small masses of detritus, and near these were numerous small haemorrhagic areas.

In the abdominal cavity, especially in the left side from the diaphragm to the symphysis pubis, there were large masses of coagulated, chocolate colored blood, inclosed in the yellow-spotted omentum. The pancreas was flaccid and consisted nearly wholly of loose shreds floating in dark and half firm clots of blood. The other organs were normal.—*Norsk Magasin for Laegevidenskaben*, No. 2, 1893. [The admirable studies of Fitz have crystallized our knowledge on this subject and brought it within the scope of the diagnostician. It is much more frequent than is generally supposed. In this case the abdominal pain did not appear to be a marked feature; it usually is. A diagnosis of acute intestinal obstruction or of acute perforative peritonitis is usually made. Infarction of the superior mesenteric artery is a condition which presents a similar set of symptoms.—Eds.]

**PERFORATION OF THE INTERVENTRICULAR SEPTUM.**—Prof. Potain recently observed a woman of 55 years, the mother of three children, who had always been in excellent health, but who presented on examination an enormous cardiac murmur, of a high pitch and superficial character, in the left third intercostal space; it could be heard to be transmitted along the large vessels. From this he concluded that there was an interventricular communication between the ventricles, but which had existed all through life without determining any disturbance of health. This supports the view of Prof. Roger that a congenital heart lesion, if very important, may exist without compromising the patient's health.—*La Semaine Médicale*, No. 21, 1896. At a recent meeting of the Society of the Hospitals of Paris, Dr. Siredey reported having observed a young man of 19 years, who after death presented a stenosis of the pulmonary artery, a persistence of Botal's foramen and a perforation of the interventricular septum. On his entrance into the hospital he suffered from no disturbance of circulation. Dr. Barth has reported the case of a woman who lived to the age of 49, and whose heart after death was found to have but one ventricle.—Eds.]

**PROGRESSIVE PERNICIOUS ANÆMIA AND ITS RELATION TO DISEASES OF THE STOMACH.**—Prof. Hayem, of Paris, has recently observed two cases of pernicious anæmia where the state of the blood seemed to be dependent upon a gastric lesion, in one an atrophic gastritis and the other a mixed gastritis. These go to demon-

strate that no one stomach disease is at the bottom of pernicious anæmia.—*La France Médicale*, No. 14, 1896. [Dr. Menétrier, in the same journal, records two cases of this disease where the stomach, post-mortem, both microscopically and macroscopically, was wholly normal. Dr. Lazarus, *Berliner Klinische Wochenschrift*, No. 14, 1896, calls attention to a peculiarity of the red blood corpuscles in pernicious anæmia. On looking through the blood specimens, one will notice on careful inspection dull-gray and fine points, which are imbedded in the red corpuscles. They are only visible when they are heaped together in large masses; they may be diffused throughout the entire cell corpuscle or only in a part. The writer has found this to be characteristic of every case of pernicious anæmia whose blood he has examined for the past three years—twenty cases. In other diseases of a similar character, as anæmia of syphilitic or carcinomatous origin, this was never observed. He ascribes this appearance to disintegration of the cellular contents. In this disease he regards the formation of the red corpuscles as no longer that of adult life, but of an embryonic type.—Eds.]

**GONORRHOEAL PYELO-NEPHRITIS.**—Dr. Mendelsohn communicates the case of a man of 70 years who, about a year before, had fallen severely sick with dyspnea, swelling of the legs, with final extension of the œdema over the whole body. For six weeks he lay very sick and near death's door. The attending physicians had diagnosed Bright's disease with dependent dropsy. He recovered slowly and remained miserable. He especially complained of pains in his back, on both sides of the spinal column, and he had trouble in passing his urine, which latter he attributed to his age. Although an hypertrophic prostate was suspected, a nearly impassible stricture was found, which must have dated back forty-five years, as he swore that he had gonorrhœa but once, and that then but a mild attack. This stricture was dilated, and with the increase of size in the urethra his symptoms improved. When first observed, his urine was acid, turbid, contained considerable albumin with granular and hyaline casts, as well as leucocytes, and several varieties of epithelium; now it is entirely clear, presents only traces of albumin and but few casts, and, above all, his whole condition is greatly ameliorated. The case is of interest in that it shows that one should, in renal diseases, never neglect to examine the urinary passages, for an old and forgotten gonorrhœa may have left behind it a stricture which will lead to a dangerous renal affection. Gonococci were to be detected in the urinary sediment in this case.—*Berliner Klinische Wochenschrift*, No. 14, 1891. [When these cases have gone on for some time and become suppurative, an interesting condition may develop, which is characterized by intermittent fever, associated with chills, recurring at regular intervals. These cases are often mistaken for malaria. These rigors frequently form a characteristic feature of calculous and tuberculous nephritis. Ultimately, the fever assumes a hectic type and the rigors may cease.—Eds.]

**BALSAM OF PERU IN SCABIES.**—Dr. Jullien, of Paris, has treated three hundred cases of itch with inunctions of balsam of Peru. This drug contains an essential oil which is very toxic for the parasite. Energetic frictions are not necessary, as the vapor will kill the animal. The patient is rubbed in the evening for fifteen to twenty minutes with the balsam, after which he sleeps in a shirt impregnated with the drug. The following morning he takes a bath. This method of treatment is not more expensive than the ordinary, and it is especially indicated in those with secondary eczema, pustular skin affections, in debilitated subjects, patients with heart diseases, pregnant women and nurseries. In the form of a salve it is highly recommended in itch in children. —*La Semaine Médicale*, No. 20, 1893. [T. McAll Anderson, *Diseases of the Skin*, Philadelphia, 1887, p. 55, also speaks very warmly of this drug in the treatment of the itch. He says that the patient should not be perspiring at the time, nor should he have a bath before it, as the drier the skin the better it can be rubbed in. One thorough application is sufficient, or the balsam may be diluted with two parts of lard and be applied oftener.—Eds.]

**THE TREATMENT OF TYPHOID FEVER.**—While it is true that the modern treatment of typhoid fever is chiefly dietetic, there are a number of drugs by which the various symptoms may be modified or relieved. Thus it is sometimes necessary to administer remedies to reduce high fever, to relieve sleeplessness and quiet the nervous system, and to exert an antiseptic action upon the intestinal canal. Some authors have claimed that all these effects are embodied in a single remedy, namely, phenacetine. Dr. Giovanni Bignami (*Gaz. d. Osped.*, No. 35. 1896), has

recently reported that for the past four years he has employed phenacetine exclusively in the treatment of typhoid fever with very favorable results. Among two hundred cases in private practice only six died, and these fatalities were mainly to be ascribed to unfavorable conditions of nutrition and hygiene. In the majority of cases (123) the typhoid was complicated with pulmonary and meningeal symptoms. The author believes that in genuine ileo-typhoid he obtained a real abortive action from the use of phenacetine. As soon as the diagnosis of typhoid has been made he orders 3.0 gm. in six doses, one powder to be taken every four hours, and continued in this manner for the entire first week. In children and aged persons the daily dose is reduced to 2.0 or 1.5 gm. daily according to the strength of the patients. After the lapse of the first week he continues the drug regularly in 0.5 gm. doses every six hours to adults, and to children and the aged in 0.25 gm. doses as long as the thermometer shows a higher temperature than 33° C. Only very rarely he observed cyanosis of the face, which, however, was transient; and in not a single case did vomiting or cutaneous eruptions occur, as well as nephritis, hematuria, or collapse. A remarkable phenomenon in all these cases was the profuse diaphoresis which sometimes required reduction of the dose. In general the tolerance for the remedy is excellent, and the disease generally runs a favorable course. In several instances of recurrences from dietetic errors and auto-reinfection phenacetine likewise proved very efficient. The pronounced abortive action of phenacetine is most readily explained on the ground of its diaphoretic property and the investigations of Omeirolo have shown that diaphoresis is one of the most important preventives against infection and toxæmia. Aside from this the author believes that phenacetine undoubtedly is taken up into the blood and serves to neutralize the effect of the typhoid poison.

**VASO-MOTOR ÖDEMA WITHOUT ALBUMINURIA.**—Dr. B. Tchirkoff, of Kieff, Russia, describes an interesting and rare disease where there is decided oedema without associated albuminuria. In all he has seen seven cases. The patients varied from twenty-five to sixty years in age and were of a robust constitution. As a rule the oedema developed in the course of three to four months, as in a typical case of chronic nephritis, possibly with preceding anaemia; in a few cases it was rapid in appearance. In the course of a week there was considerable oedema of the extremities and trunk, as well as of the head. There fluid would collect in the peritoneum, and in two weeks longer both in the pleural and pericardiac cavities. Only in one case was the lower portion of the body affected alone. Some of the patients lost their hair, of the head, beard and pubes. The corpuscular elements of the blood were fully normal. Characteristic, though he found for the disease a considerable quantity of reduced haemoglobin. There was in these cases no mechanical hindrance to circulation in the large veins, no heart-weakness, whence the writer ascribes the oedema to the nervous system and thence to the vaso-motor centre when the oedema was general. All the patients were very emaciated and reduced in strength after the disappearance of the oedema. In five of the cases syphilis was detected in the history.—*Norsk Magazin for Lægevidenskaben*, No. 2, 1896. [Osler (*Ibid.*) describes a similar, though a more localized diseased state under angio-neurotic oedema. He states the disease to have affinities with urticaria, the giant form of which is probably the same disease. He cites Quincke to the effect that it is held to be a vaso-motor neurosis, under the influence of which the permeability of the vessels is suddenly increased.—Eds.]

**TRANSMISSION OF INFECTIOUS DISEASES BY MEANS OF BOOKS.**—Drs. Du Cazal and Catrin have found from bacteriological experiments that a number of varieties of micro-organisms may adhere to and be carried about by books. The bacilli of tuberculosis, however, were not to be transmitted in this manner, though daily experience has proved the possibility. In England very radical rules are carried out in some places; for example, the physician must report to the libraries the cases of infectious diseases, and in case a book is returned from a family, for example, with small-pox, the book is burned. Unbound books are easily disinfected, as well as letters and lithographs, so that patients with infectious diseases should not be hindered in corresponding with their friends if their mail be disinfected. Bound books cannot be disinfected, as the binding will not bear the process. The writers warn against carelessness in the use of books in schools, sanatoria, etc., for infectious diseases may undoubtedly be transmitted thus.—*Hospitalstidende*, No. 6, 1896. [Dr. Lepine has reported a case of scarlatina where infection was transmitted by a letter.—Eds.]

## GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D., AND H. L. NORTHROP, M.D.

**PYLORECTOMY.**—Ferguson presents a study of cases of pylorectomy for carcinoma in North and South America, and states that upon opening the abdomen and determining the extent and, as near as possible, the nature of the pathological conditions, two important problems are at once confronted: (a) Will the strength of the patient permit with reasonable safety the performance of an operation that is necessarily grave and often prolonged, and (b) is the disease so limited as to warrant its extirpation?

When the afflicted person is emaciated and weak from starvation, or takes the anesthetic badly, even though the disease can easily be removed, it is in the best interests of the patient to desist and do the simpler and less serious operation of gastroenterostomy instead, with the hope of obtaining later on a more suitable constitutional condition which would warrant attacking the carcinomatous pylorus. When the cancerous mass is fixed or has extended to the liver, pancreas, or other surrounding structures, no attempt whatever should be made to remove it.

A suitable case for pylorectomy then would be one whose age is comparatively young, whose strength is at least fair, whose behavior under the anesthetic is good, and in whom the disease is still limited to the pyloric end of the stomach.

For the treatment of carcinoma of the pylorus Ferguson is strongly in favor of encouraging pylorectomy, for the following reasons:

1. Medical treatment offers a mortality of 100 per cent. within twelve or eighteen months.

2. Pylorectomy promises (a) a possible cure. In 19 per cent. of over 900 cases dying with cancer of the pylorus, no adhesions whatever were found after death; starvation took place before the carcinoma had reached the peritoneum. There should be good prospects of curing most of these. (b) Recovery from the operation in about 50 per cent. Death occurs in 43.7 per cent. while the disease is still local, i.e., no secondary deposits or extension beyond the pylorus. Surely some of these can be saved. (c) A still less mortality with early operation. By a timely interference many cases would be saved that now go on to secondary infection and are doomed.

To secure the best possible results shock must be anticipated and means taken to prevent it. In addition to the hypodermic injection of strichnine before the operation is begun, the writer is convinced, from a large experience in major work, that when the patient is placed on a hot-water bed during the operation that shock, which otherwise would have been pronounced, is in many cases altogether prevented. The author feels certain that this precaution was a material contributing element to the success of pylorectomy. Another was the rapidity with which it was done. Credit is given to Murphy's button for greatly shortening the time of the operation, for with it only six minutes were taken to do the gastro-duodenostomy. Take these cancerous pyloric cases—cachectic, emaciated and starved as they usually are when sent by the physician—just do nothing but give them surgical narcosis for three hours on a cold glass slab, and it may be very much doubted whether all would recover from the shock of the anesthesia. The author is constrained to emphasize a) the utility of dry heat and (b) short anesthesia to prevent shock.

We further quote from Ferguson's article: "After opening the abdomen, I should recommend the performance of pylorectomy as follows:

"1. Liberate the duodenum from the pylorus, unite its distal cut end to the posterior surface of the stomach, invert the proximal cut end toward the pylorus, and close with sutures. The great advantage of completing the gastro-duodenostomy first, is that the operation can be safely stopped at this stage should the patient show signs of weakening, the abdomen at once closed, and the removal of the pylorus left for a second operation.

"2. Separate the stomach from the pylorus and close it up rapidly with sutures. Should the patient now present alarming symptoms, the surgeon may again cease operating and leave the pylorus *in situ* in the meantime. It would, of course, be necessary to fasten it in the abdominal wound and drain it externally, which, however, would only facilitate its extirpation.

"3. Remove the cancerous pylorus. Spend no time trying to use interlocking

ligatures, but apply forceps after forceps and cut the mass away. When this is all done, the application of ligatures can be executed more expeditiously."—*International Journal of Surgery.*

**SURGICAL HINTS.**—When you have found pus in an exploratory puncture, never take out your needle, if the case is one for operation, until the pus cavity has been widely opened.

Do not use the old fashioned curved bistoury in opening the simplest abscess. It is unsurgical because you proceed from within outward—from the unknown to the known. This is a false principle in philosophy, in surgery, and in everything. Cut from the surface inward and you can deal with difficulties in the order in which they occur. Always work with the aid of sight and do not pin your faith on anatomy.

A heaping tablespoonful of washing soda to a quart of water is the proper proportion for the solution in which instruments should be boiled for sterilization. Do not boil non-metallic sutures in this liquid, for it will greatly weaken them. Do not boil an aluminum instrument in this liquid, for it will be corroded and completely ruined. Silk sutures and aluminum instruments may be sterilized by boiling in 5 per cent. carbolic.

General anæsthetics are used far too often. A 2 per cent. boiled solution of cocaine hydrochlorate injected, with a sharp needle, into the skin, not under it, will enable one to perform such operations as castration, the removable of non malignant breast tumors, even if they are as big as a cocoanut, many herniotomies, where there is strangulation, and the removal of almost any subcutaneous tumor up to four pounds in weight. Intra-abdominal work, however, to be well done, requires general narcosis.

Examine the urine for sugar in all cases of carbuncle and in all cases of eczema, especially in eczema of the genitals.

Never operate for chronic tumor without having tried anti-syphilitic remedies for at least a week. Many growths supposed to be beyond surgical skill, fairly melt away under the benign influence of mercurial ointment or iodide of potassium. This clinical test is far surer than the microscope.

In cases of severe injury to the fingers by laceration or contusion, put the entire hand into a very ample soaking-wet dressing. Do not even trim off a piece of flapping skin. Incision for drainage is all that is allowable until healing is very well under way or even quite complete. You may then look over the ground and see whether it is worth while to sacrifice anything. A half-inch of boneless finger may be of incalculable value to its possessor.—*International Journal of Surgery.*

**CALCIFICATION OF THE TUNICA VAGINALIS, IN HYDROCELE; OPERATION, WITH RELIEF OF MENTAL SYMPTOMS.**—Park observed the interesting case of a patient of sixty-three years who suffered from a singular form of melancholy or mania concentrating itself upon his enlarged testicle which for six to eight years had been hard, resistant and of extreme size. From his age and the hardness of the growth a malignant tumor was thought of. As the patient demanded its removal an operation was done, at his request, without anæsthesia. During the whole operation he gave no sign of pain. The tumor was found to be about five inches long and four inches broad. Its walls were solid and sounded, on percussion, like an egg shell; it was ovoid in form. Indeed, it seemed in consistence and size to resemble an ostrich egg. On cutting into the wall it was seen to be from one-eighth to one-fourth of an inch, in thickness. In the interior there were eleven ounces of a fluid which formerly must have been pus. The epididymis was quite thickened but its tissue did not appear to be diseased. The lower-most portion of the cavity contained two cysts which were filled with a cheesy matter consisting of cholesterine and fat. Curiously enough after its removal, the patient was cured of his mental disease.—*Wiener Medizinische Presse.*

**DIACHYLON PLASTER IN ATONIC WOUNDS AND ULCERS.**—Baldazzi, in atonic wounds or ulcers, either of spontaneous or operative origin, advises compression by means of strips of diachylon plaster. It has the advantage of being easily carried out, and is especially adapted to country practice. It is also of service in ulcers of the leg. In fact, in all atonic wounds of whatever origin it exercises a beneficial action. The wound or ulcer should first be rendered aseptic, and this repeated at each time that the dressing is renewed.—*La Semaine Médicale.*

## GYNAECOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D.

**VAGINAL FIXATION OF THE UTERUS.**—Discussion by the Gynaecological and Obstetrical Society of Berlin, January 24, 1896.

Dr. Flaischlen expressed his opinion that the views of Strassmann and Graefe are receiving more supporters, that vaginal fixation of the uterus should not be performed on women capable of conceiving if it can be avoided. He mentioned twenty-two cases of vaginal fixation, in four of which there were severe complications in labor, also the fact that pregnancy is liable to loosen the adhesions, and the uterus becomes retroflexed afterwards. Prof. Oshausen considered ventral fixation a valuable addition to gynaecological surgery. The tendency was to overdo it both in the indications and in its technique. He would restrict the indications to perfectly movable uteri without any disease of the adnexa, and even here it should be modified by the severity of the complaints and the age of the patient. The technique is overdone when the entire anterior wall is fixed. He introduces the upper stitch only one or two centimeters above the internal os without opening the peritoneal cavity. He uses a buried silk-worm suture, and has no trouble with it.

Dr. A. Martin thinks that the indication for the operation in uncomplicated cases of retroflexions is very rare, as a vaginal pessary will usually relieve the symptoms. He finds it a necessary supplementary operation to anterior colpotomy for prolapse operations. He uses absorbable suture material, and fixes the uterus two or three centimeters below the fundus, but he does not hesitate to fix the fundus if myomas have been removed from this portion of the uterus with more or less loss of substance. The relatively rare occurrence of pregnancy after his operations he ascribes to pelvic peritonitis, which in a great majority of the cases has been the primary indication for the operation.—*Centralblatt für Gynäkologie*, No. 10, 1896.

**A NEW TREATMENT FOR UTERINE HEMORRHAGE.**—Berman.—Labadie-Lagrave has used a mixture of salol and antipyrine with prompt success in many cases of metrorrhagia and menorrhagia. Equal quantities of salol and antipyrine are warmed over a lamp, in a glass tube, till they are deep brown, and allowed to cool. A fine uterine probe, wound with cotton, is dipped in the liquified mixture and applied direct to the uterine cavity two or three times in succession. The application is painless, and not followed by unpleasant symptoms. A second application is rarely necessary. Labadie-Lagrave has used this treatment since 1893 for uterine hemorrhage, and has had better success with it than any other. The use of the curette should precede the application if vegetations or fungosities are present.—*Allg. Wiener Med. Zeitung*, No. 35, 1895.

**COTAMIN FOR UTERINE HEMORRHAGE.**—Gottschalk.—This remedy is chemically very near to hydrastinin, and is prescribed in powder or in gelatine capsules, 0.05 G., five or six times a day, or subcutaneously, 0.02 G., in the gluteal muscles.

The drug is adapted to long use, and has a quieting, benumbing effect, conducive to sleep.

It is especially useful for the hemorrhages of subinvolution of the puerperal uterus. It has proved useful for fungous endometritis where curettage was refused; also for myomas and climacteric hemorrhages, as well as for secondary hemorrhages in consequence of exudates or adnexa tumors. It has been used for hemorrhages of a purely congestive nature, but is contraindicated in threatened abortion from the liability of causing uterine contractions.

The best method of administration is to begin one week before the menstrual period with small doses, 0.025 G., four times a day, and double the dose when menstruation commences.—*Therap. Monatsh.*, December, 1895.

**VENTRAL FIXATION AS A COMPLICATION IN LABOR.**—Milander.—In fifty-four cases of labor at full term, complicated by ventral fixation, eleven required assistance: four, forceps; two, Cæsarian sections; four, versions; and, one, extraction. If the adhesions to the abdominal wall are too extensive, the conditions

are like those after vaginal fixation.—*Zeitschrift f. Geburts. u. Gynäk.*, Bd. xxxiii., Hft. 3.

**THE STERILIZATION OF LIGATURES BY FORMOL.**—(Trétrop.) He soaks the ligatures and rubber tubing in a 5 per cent. by volume solution for twenty-four hours, and preserves it afterwards in 95 per cent. alcohol. The sterilization has been perfect even four weeks afterwards.—*Centralblatt für Gynäkologie*, No. 15, 1896.

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## OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

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**RETRO PHARYNGEAL ABSCESS OF INFANCY AND CHILDHOOD.**—Dr. Henry Koplik says: "A study of my seventy-six cases shows that the acute retro-pharyngeal abscess is pre-eminently a disease of infancy. Out of this number there was only one patient who was as old as nine years. It is most frequent from the sixth to the twelfth month, and after the second year of life it is quite uncommon. It is most frequent during the period of suckling. I have followed a number of these cases from a simple angina to the full development of the acute abscess. The physical signs of acute retro-pharyngeal abscess are the only certain means of diagnosis, although, of course, the voice and cry undergo a remarkable change. Sometimes the head of the patient is thrown back, the infant refuses to nurse, breathes with difficulty, and awakens at times with a start. The symptoms may be easily mistaken for acute laryngeal disease, or acute paralysis of the fauces. If the fauces are inspected while the head of the infant is thrown back, there is a distinct prominence observed to one or the other side, due to the vertebra. The only accurate method of investigation is by digital exploration. Such a procedure in a young infant is not free from danger. I have known it to be followed if done roughly, by great prostration. There may be simply an enlargement of the retro-pharyngeal lymph-nodes, without suppuration. Sometimes the abscess is low down, opposite the larynx, and hence is not visible in the fauces. It is unfortunate to have the abscess rupture during the examination with the finger, for it is quite likely under such circumstances that the pus will flow down into the larynx.

When these cases of retro-pharyngeal abscess are left to nature, the abscess bursts and results in spontaneous cure—at least that has been my experience in a few cases in which it has been impossible to obtain the consent of the parents to operate. I think some writers have exaggerated the danger of leaving these cases to nature. It has been claimed that death is liable to follow from the bursting of the abscess during sleep, resulting in suffocation. These abscesses open and discharge very gradually through a minute opening. I do not favor this let alone treatment, but I wish to emphasize the fact that the danger of not incising these abscesses has been overdrawn.

In certain cases of retro-pharyngeal abscess, asphyxia early supervenes, and death seems imminent. In my cases there was one case in which the infant was operated upon by a physician in private practice and brought to my clinic in an almost moribund condition by the physician. Moist râles could be heard all over the chest, and it is probable in this case that pus was aspirated into the bronchi. In one of my cases basilar meningitis occurred as a complication; in another there was Schluckpneumonie. The peculiar condition of prostration following the opening of the abscess in some cases has been thought to be due to pressure on the nerves, producing reflex syncope.

There is the greatest diversity of opinion, even among those of large experience, regarding the best method of treatment. External incision has been advocated because by the internal incision it is difficult to keep the parts clean and the wound open. There are distinct sets of cases in which the internal incision is entirely sufficient; in others, the external incision is better. In the vast majority of my cases, those in which the abscess pointed in the middle line of the fauces, the internal incision was effective, and gave immediate relief. A free longitu-

nal incision, subsequently enlarged by a forceps guarded by the finger, rarely closes up. It is not often that it becomes necessary to repeat the incision. Over 70 per cent. of these cases occur in sucking infants who have few, if any teeth, and the demands for antisepsis are not as imperative as in adults. For this reason I think the internal incision will be found ordinarily sufficient. The infant should be undressed and held firmly by an assistant in a good light. With a bistoury, the blade of which has been protected to within a half-inch of the tip, an incision is made longitudinally from above downward, inclining, if at all, toward the median line. When the incision is made, the assistant holds the infant face downward, so that the pus may escape from the mouth. This is facilitated by external pressure on the side of the neck. The opening is then dilated, as already described. It is unfortunate to incise a case in which suppuration has not occurred. After the incision has been made, the external pressure is all that is necessary to cause evacuation of the pus. In another class of cases the deep cervical glands at the side of the neck are also involved. On inspection of the mouth, the abscess appears at the side of the neck. The external swelling is quite extensive, but well covered by muscles and the soft parts. In such cases the abscess is better approached from without by carefully incising or dissecting from without inward. It is exceptional, however, to need a general anaesthetic for such cases. The burrowing septic abscesses should of course be treated by external incision.—*Amer. Medico-Surgical Bulletin*, April 4, 1896.

**THE AFTER-TREATMENT OF TRACHEOTOMY CASES OF MEMBRANOUS CROUP** was the title of a paper read by Dr. R. M. Harbin, of Rome, in which he drew the following conclusions :

1. Croup, whether diphtheritic or membranous, is almost invariably fatal without surgical treatment, and the few cases that recover by medical treatment alone are not to be considered.
  2. So far as the practical indications for tracheotomy are concerned, it makes no difference whether croup be diphtheritic or membranous.
  3. Tracheotomy has the advantage over intubation, in that it gives a better means of expectorating the membranes and furnishes free drainage from the site of septic infection.
  4. Tracheotomy is a justifiable surgical procedure, and should be performed in all cases where our therapeutic resources have been exhausted, and where the patient is in imminent danger of suffocation. It should be done in hopeless cases, since it either offers a chance for the patient or promotes euthanasia.
  5. Tracheotomy keeps the patient alive until the pseudo-membrane disintegrates and resolved into a muco purulent liquid and is expectorated through the tube.
  6. The after-treatment is the most important part of the procedure, and the author attributes the successful results reported to the persistent use of lime-water.
- Med. Surgical Bulletin*, April, 1896.

**TURBINAL HYPERSTROPHY IN RELATION TO DEAFNESS.**—Dr Jones concludes that :

1. Turbinal hypertrophy must be regarded as a serious complication of deafness and the allied aural disorders; and where it precedes the aural symptoms, it may be justly looked upon as a principal cause.
2. In all cases in which hypertrophic change is discovered, active therapeutic measures, the galvano-cautery, etc., should be adopted.
3. Deviations of the nasal septum, or growths from it, are rarely the cause of deafness unless they complicate turbinal hypertrophy.
4. Deviations producing occlusion of the nostril should be rectified.
5. Turbinotomy should be reserved for those cases where other treatment fails to give relief.—*Med. Press and Circ.*, October, 1895.

**THE TREATMENT OF SIMPLE CHRONIC GLAUCOMA.**—Abadie has given up all operative interference in chronic glaucoma, and recommends the systematic and prolonged use of miotics. In addition, he gives internally potassium bromide associated with quinine sulphate, as follows: He gives every day for a month a dose of 15 to 30 grains of bromide of potassium, and every other day from 30 to 50 centigrammes of quinine. A few drops of a solution of eserine or of pilocarpine, or the two combined, are instilled into the eyes once a day. At the end of a month the internal medication is suspended for eight days and is then resumed in the same way, and kept up indefinitely as long as may be necessary.—*Archit. Ophthalmol.*, November, 1895.

**MONTHLY RETROSPECT  
OF HOMEOPATHIC MATERIA MEDICA AND  
THERAPEUTICS.**

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CONDUCTED BY

CLARENCE BARTLETT, M.D.,  
FRANK H. PRITCHARD, M.D., AND F. MORTIMER LAWRENCE, M.D.

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**THE THERAPEUTIC TREATMENT OF UTERINE SUBINVOLUTION WITH SALTS OF POTASSIUM AND GOLD.**—In the *Hom. Journal of Obstetrics, Gynaecology and Paedology* (March, 1893), Dr. George Burford writes: "On Subinvolution of the Puerperal Uterus, with Some Remarks on a New Therapeutic Treatment with Salts of Potassium and Gold." After tracing the natural history of subinvolution in its finer tissues as a pathological basis for an adequate and effective treatment, indicating the steps by which the uterus passes from the early phases of defective repair to that hypertrophied, dilated and indurated state known as chronic metritis, he concludes that we should regard subinvolution as an issue, as preventible as is ophthalmia neonatorum or puerperal septicemia. Regarding the prime factor as a vasomotor derangement, and the secondary issue as deranged tissue-generation, as remedies germane to the former, he recommends nux vomica, belladonna, lily tigr., sulphur, pulsatilla, etc.; for the trophic defect, kali carb., chlorat., bromide, etc., with aurum met., aurum et kali chlor., etc. His recent investigations point clearly to the fact that potassium salts exert a specific influence on the nutrition of the uterus. Forty per cent. of the mineral structure of the uterine muscle consists of potassium: as iron is to haemoglobin, as lime is to bone, as sodium is to bodily fluids, so is potassium to unstriped muscle. Pharmacologists are unanimous in ascribing to potassium in concentration an undoubtedly poisonous action on unstriped muscle, and Brunton shows clearly how small quantities of potassium salts invigorate this structure and increase its capacity for work. The physiological provings of the salts of potash show that the combinations of this alkali act primarily upon nerve ganglia and secondarily upon muscle fibre. That this influence is of a trophic character, seems highly probable, and the more so in that parallel phenomena are seen in the action of other drugs on tissue nutrition.

Now Dr. Burford assumes that often after parturition the uterine trophic ganglia are unequal to the strain of the rapid manufacture of normal muscle fibre; that the uterine tissues thus generated are defective in vital and chemical integration; and that in part this defect is shown in the insufficient incorporation of potassium salts into the new muscle. Dr. Hughes has enunciated the proposition that of mineral elements used in tissue building small doses, acting dynamically, will control the trophic process of selection of these from the food; for instance, the administration of small doses of iron will accelerate the integration of iron in the haemoglobin, and the writer believes that small doses of potassium will increase and multiply the power of the nascent uterus in assimilating potassium salts in the requisite degree. Clinical verification is to be found in the opinion of Lawson Tait that bromide of potash is a specific cure for simple subinvolution, and in the writer's experience with the drug in doses ranging from five-drop doses of the x solution to five grains thrice daily. After quoting clinical recommendations of aurum in uterine induration, Dr. Burford agrees with a writer in the HAHNEMANNIAN MONTHLY for January, 1894, that the salts of gold show in their provings their component parts, and decides that a chemical union of gold and potassium promises a resultant action which shall, in whole and in detail, effectively counter-check all the morbid elements of subinvolution. No such salt was in use, but at Dr. Burford's request, Merck, of Darmstadt, prepared a supply, and its use in both hospital and private practice has been attended with most gratifying results. Dr. Burford summarizes his conclusions as follows.

He regards potassium salts as a nutritive necessity to the regenerating post-partum uterus.

He regards potassium salts, used in dynamical preparation, as essential for the rectification of those trophic aberrations which constitute the early stage of subinvolution.

He regards potassium salts, in their action on a subinvolved uterus, as acting essentially in a manner similar to iron in anæmia or calcium or silica salts in rickets.

He regards the conjoint use of some remedy out of Series I. (remedies germane to the circulatory defect), as necessary where a potassium salt is given, for the necessity is two fold—circulatory and nutritive.

He regards the use of aurum in the later stages of subinvolution as most valuable in the treatment of the indurated uterus, and its combination with potassium as furnishing an ideally complete drug for the treatment of the main tissues in subinvolution.

**THE EFFECTS OF THE BROMIDES**—At the recent session of the “Association of American Physicians” at Washington, Dr. S. Weir Mitchell presented a paper upon “Certain Effects of Bromine Intoxication,” and evil effects detailed, as recorded in the abstract of proceedings given by the *American Medico-Surgical Bulletin*, should be very valuable indications as to the sphere of these drugs in homœopathic therapeutics. The author took the ground that the use of bromides, especially in excess, often produced very peculiar results, and the symptoms for the alleviation of which the drug was taken often became much worse under its use, especially during menstruation. It caused delusions, suicidal tendencies, etc. Irritability of temper was a frequent result of the use of bromides, but the more serious effects were rarer. It also had some effect on the urine. In chronic cardiac asthenia the symptoms grew worse under the use of bromides. A tendency to ptosis was a common sequence. He had also seen it produce paresis and an inability to walk, sometimes more marked on one side of the body than the other, simulating hemiplegia. In this it resembles the well-known effects of alcohol, where it was noticed that a man appeared to be more drunk on one side than the other. The left side was the one more commonly affected. The use of bromides also led to failure of memory, going on to partial paresis and involuntary movements of the bowels and rectum. These extreme cases were rarely seen, but the reckless use of bromides by laymen might cause them. He recalled a case of Jacksonian epilepsy where 60 grains of bromide of potassium a day were given. The child's father was a druggist, and he argued that if 60 grains kept the disease in check, two or three times that amount ought to cure it. The child sank in a heap after taking the larger dose and became an imbecile. Improvement took place when the bromide was withdrawn, and her mind became sharper. He related the cases of two other children in the hospital who were taking bromide of lithium, and one lost all memory of words, while the other lost all idea of time. He also mentioned the case of a lady who had been taking 60 grains of bromide a day four years. Suicidal tendencies and melancholia occurred at the menstrual epochs, which disappeared when the bromides were withdrawn, and reappeared when she resumed their use a few years afterward. He strongly inveighed against “deluging” patients with bromides, especially in cases of epilepsy.

**PICRIC ACID IN REFLEX NERVOUS DISTURBANCES**.—According to Dr. W. A. Dewey, picric acid is a useful remedy in peripheral nervous disturbances, such as occur as the result of retroflexion of the uterus. There is a feeling of burning and weakness in the lower back; tearing in the lumbar region; the legs are heavy and weak with numbness, crawling, and pains; often, too, frontal headache. In uterine complaints it often may come in as an intercurrent or finishing remedy. There is a general tendency to coldness, especially of the extremities; in fact, the whole organism seems in every way “below par.”—*Medical Century*, March 15, 1898.

**THE NERVOUS SPHERE OF CUPRUM**.—According to Dr. W. Dewey, *cuprum* is one of our great remedies in meningitis, and clinically it has proven itself useful in meningitis from suppressed eruptions. When convulsions are present, there is a violent headache, with intermitting, lancinating pains in various parts of the head. The patient screams out and the convulsions are most violent, the thumbs are clenched, the eyeballs rotate constantly, the face is pale and the lips are blue.

The patient bites the tumbler; on awaking from sleep he is frightened. There are clonic spasms commencing in the fingers and toes, and spreading. *Cuprum* is one of our best similiums to convulsions and spasms. To that opprobrium of medicine, epilepsy, it is perhaps conceded to be the oftenest indicated remedy. It is characterized by the extreme violence of the convulsions, and the face is pale. Bayes remarks that he has "cured some cases of epilepsy with cuprum (6 or 12)," but has "had more failures than cures," while Dr. W. M. Butler remarks, "In our hands no other remedy has as often proven curative." Other indications are cold sweat, blueness about the mouth. The ushering in of the convulsions with a shrill, shriek, or cry, further indicates the remedy; epilepsy occurring at night or during menstruation. The return of the fit is usually regular and the convulsive movements commence at the fingers or toes, or in the arms. The attack is followed by headache. Convulsions in children during dentition, and if caused by the suppression of exanthemata, will often call for *cuprum*. There is blueness of the body, clenched hands, the body is stiffened and bent forward, and the muscles and tendons are contracted. Uræmic convulsions, especially if they follow an attack of cholera, will call for this remedy. Cramps in the muscles, convulsive movements and spasms of all kinds call for *cuprum*; the severe nervous phenomena of laryngismus stridulus and whooping-cough are also well met by this remedy. Angina pectoris may also call for *cuprum*. There are sudden attacks of dyspnoea or suffocation, with a slow pulse.

Chorea finds in *cuprum* its remedy when it is periodical with irregular movements commencing in the toes; twitching is often confined to one side and is better when lying down; there is often laughter and grimaces accompanying. In hydrocephalus, acute or chronic, *cuprum* may be the remedy, especially if it be brought on by a retrocession of an eruption. There will be delirium, convulsions, stiffness of the neck, skin very pale, cold hands and feet, trismus or tetanus; cannot hold the head up; it comes in better in the stage of exudation. In myelitis, when there are jerking and twitching of the muscles, short, oppressed respiration, stiff, lame feeling in the back and lumbar region, spasms of extremities, weakness, prostration and debility, *cuprum* will be indicated. *Cuprum* produces paralysis of all the muscles of the back up to the neck, also paralysis of the limbs; the lower limbs become oedematous, but retain their sensibility. Paralysis after cholera or typhus. Neuralgia, especially when of the abdominal viscera, will call for *cuprum*; the pains are severe, cramping and not relieved by pressure. Here, also, *cuprum arsenicum* is sometimes better than the *metallicum*.—*Medical Century*, May 1, 1896.

**A CASE OF PEMPHIGUS TREATED BY ARSENIC, WITH RESULTING ARSENICISM.**—Under the above title H. V. Munster reports the case of a woman, aged 56, suffering with pemphigus, who for about seven weeks received *liqor arsenicatis* in doses varying from 2 to 6 minims at intervals of a few hours. The disease was cured, but a gastritis had in the meantime been set up, and finally the patient was suffering as follows:

*Complaint.*—A severe cold in the head. Feeling very ill.

*Digestive System.*—No appetite. Thirsty. Tongue is covered with thin white coating, under which red base can be made out. Diarrhoea with straining, but this is less severe than a day or two ago.

*Respiratory System.*—Profuse coryza. Alæ nasa and upper lip much excoriated. Nasal discharge thin, watery and acrid. Marked sneezing, which is specially troublesome at night, when all other symptoms are aggravated. Slight cough.

*Urinary System.*—Says urine was dark before "cold" came on. It is now clear and passes freely.

*Nervous System.*—A severe neuralgic right-sided headache appeared before the coryza set in. This is better now. Complains of great weakness languor, anxiety and depression. Feels restless, especially at night.

*Sense Organs.*—Profuse lacrimation. Eyes look very suffused and conjunctiva red. Marked œdema of subcutaneous tissue of lower eyelids.

The liq. ars was discontinued, and after a few days' treatment with *ipecac*, 1x, and *cinchona*, 1x m. i. h. 3 alt., she was very much better.—*Monthly Hom. Review*, May 1, 1895.

**ANTIMONIUM CRUDUM IN BLEPHARITIS.**—This drug has cured, or assisted in curing, some obstinate cases of blepharitis, in which the lids have been inflamed, swollen and moist, with pustules on the face; especially when occurring in cross, peevish children.—*Hom. Eye and Throat Journal*, April, 1896.

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## THE PRINCIPLES UNDERLYING THE SOLUTION OF QUESTIONS OF SCIENCE WITH SPECIAL REFERENCE TO HAHNEMANN'S LAW OF SIMILARS.

BY CONRAD WESSELHOEFT, M.D., OF BOSTON, MASS.

(Read before the *Materia Medica* Conference, Detroit, June 16, 1896.)

THE "Committee on *Materia Medica* Conference" having proposed a list of questions, a careful consideration of the subject on my part, resulted in the proposition of another question, which, it appeared to me, should take precedence of the others. In my reply of November 30, 1895, to the secretary of the committee, this question was stated by me in the following form:

*Has the "law of similars" ever been unequivocally demonstrated by deductions from general practice, and do we not require its more formal proof by inductive experimental research?*

In the course of correspondence with the committee through its secretary, Dr. W. A. Dewey, the consideration of this question was allotted to me. In proposing it, I had hoped to see another seize upon the opportunity with avidity, and to grapple more ably with the matter than its well-meaning but rash propounder. In this I was sadly mistaken, and finding myself in the lurch as usual, I reluctantly assume the task of getting the chestnuts out of the fire, and so will plunge at once into the middle of things.

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In order to proceed most methodically, it will be best to discuss the second part of the question first: "Do we not require its more formal proof of 'the law of similars' by inductive experimental research?"

That I may approach this subject properly, it will be well to do so from all sides, beginning as far back as possible, and to try to discover as far as I can, what has been done toward its demonstration outside of clinical experience. In this way it will soon become evident that actual inductive experimental research has been very scanty, and that by far the greater proportion of the support of our guiding maxim was drawn from clinical observation, as found in the literature of the time of Hahnemann. This, for the sake of convenience, I will include in the discussion of the subject of experimental research, as far as Hahnemann was concerned. Another part shall be devoted to the consideration of the deductions from general practice by other observers during and after Hahnemann's time.

In following this inquiry, it might not be altogether useless to search deeply in literature for evidences of experiment in search of a law of cure, but it will be unnecessary for our purpose, for what we need has been long and well known, and it will be difficult, if not impossible, to find more and better evidence than is to be found in Hahnemann's first cinchona-bark test, which is as follows:

"The following is to be considered: substances which excite a kind of fever (very strong coffee, pepper, arnica, Ignatius bean, arsenic) obliterate the type of intermittent fever. For the purpose of experiment, I took twice a day for several days  $\frac{1}{2}$ -ounce (four quentchen, equal to 1 drachm) of good Peruvian bark. My feet, finger tips, etc., first became cold; I became languid and sleepy; then my heart began to throb, my pulse became hard and rapid; and intolerable anxiousness, a trembling (but without rigor), a lassitude was felt through every limb; then throbbing in the head, redness of the cheeks, thirst—in short, all the symptoms of intermittent fever peculiar to me appeared successively, but without actual rigor. Briefly stated: also the peculiarly characteristic and common symptoms peculiar to me of intermittent fever, the dulness of the senses, the kind of stiffness in all my joints, but particularly the numb, disagreeable sensation which seems to be seated in the peri-

team covering all the bones of the entire body—all these appeared. The paroxysm always lasted two or three hours, and reappeared when I repeated the dose, but at no other time. I omitted it and was well.”\*

This, so far as known to me, is the only experiment Hahnemann ever made in order to establish his principle of cure, unless we consider his numerous other provings in the light of experimental tests. This view seems to me untenable, because Hahnemann considered the proof of the law furnished by his personal test of Peruvian bark as sufficient. So that his other provings were made chiefly for the purpose of discovering the “dynamic” effects of drugs, irrespective of the law which, in the opinion of Hahnemann, already rested on a firm basis.

Still, it is not difficult to perceive that the more extended proving of Peruvian bark, as well as of other medicines, gave evidence to Hahnemann that these cured the diseases to which they were similar; for the effects of many were previously known, and comparison was thus rendered possible.

In corroboration of this, I quote the words of Hahnemann: “I found, as in the case of the other medicines, and especially in that of Peruvian bark, that this, as surely as it is very curative in some cases of disease, so surely is it capable of producing in the healthy human body the gravest symptoms of disease of peculiar kind, often of great intensity, and of long duration.” (*Pure Mat. Med.*, Vol. III., p. 99; Germ. ed., 1825.)

It is a noteworthy circumstance that, instead of pursuing his inductive method further, for the purpose of still more confirming his newly-discovered law of cure, Hahnemann preferred to resort to the medical literature of his time for the discovery of other evidence, and it may seem strange to us that he chose this instead of the testimony of his own senses. It will be interesting and instructive briefly to examine some of this evidence, most of which he has recorded in the *Organon*.†

His quotations of clinical evidence may be divided into two classes: The first relating to the effect of *dissimilar diseases*,

\* Hahnemann’s translation of *Cullen’s Mat. Med.*, Leipsic; Schweikert, 1790. Vol. II. Foot-note, p. 109.

† For a more detailed history of development of drug-testing, see *Lectures on Homœopathy*, by R. E. Dudgeon, M.D.; *History of Homœopathy*, by Dr. Kleinert; also *History of Medicine*, by Dr. B. Hirschel.

tending to prove that these may suspend, but do not cure each other (Sect. 38); also that dissimilar effects of medicine fail to cure (Sect. 70). His observations on this subject are so well known that extensive quotations are not demanded, yet his position regarding the matter may be seen in the following passages: "Two *dissimilar* diseases existing in the human body may be of equal intensity; or, in case the *older one* of the two proves to be of greater *intensity*, then the new disease is kept away and excluded from the body." This "pathological law" is sustained by numerous observers quoted in the text. Thus, he quotes from *Larry* (*Descriptions de l'Egypte*, Tom. I.), that the Levantine plague does not visit localities where scurvy prevails; neither does it attack persons suffering from herpes. According to *Jenner*, vaccination proves abortive in persons suffering from rickets. *Von Hildebrand* says that patients in the ulcerative stage of consumption are not infected by fevers of a mild epidemic form.

In Sect. 38 Hahnemann demonstrates "that, in case the new dissimilar disease is of greater intensity, the first disease affecting the patient, being the weaker, will be postponed and suspended by the superadded intenser malady, until the latter has terminated its course, or has been cured." In support of this law, Hahnemann quotes numerous authors, of whom a few examples may suffice: "Thus, *Tulpius* (*Obs. Lib. I., 8*) informs us that two children, affected by a species of epilepsy, were at once free from that disease when they were attacked by *tinea capitidis*; but as soon as the eruption disappeared from the head, the epilepsy returned in the same manner as before." It was observed by *Schoepf* (*Hufeland's Journal*, XV., II.) "that itch disappeared when scurvy attacked the patient, but came to light again after the scurvy was cured." In other instances, measles were seen to arrest the inflammation caused by the inoculation of smallpox virus; in other cases, the measles actually prevented the eruption of smallpox until the former had completed their course, when the variola reappeared, etc.

In various sections, e.g. in 50 and 52, etc., H. demonstrates that, though diseases may suspend each other, they are not available as therapeutic measures on account of their uncertainty and consequent danger. From this it follows that only well-tested medicines are to be used for curative purposes, ac-

cording to the law of similars, which also finds its analogous processes in pathological and clinical reports. Thus in Section 43 H. says: "But the result is far different when two *similar* diseases meet in the organism; that is, when a stronger and similar disease is added to the one already present." In the two following sections (44 and 45) it is asserted that "two diseases, *similar* in character, cannot, like dissimilar diseases *repel* or suspend each other; on the contrary, two diseases, though different in kind, but very similar in regard to their manifestation of suffering and symptoms, will always extinguish each other whenever they meet in the organism."

In support of this broad statement H. selects his examples from a limited class of diseases which, arising from a fixed miasm, are always uniform and known by a definite name. Prominent among them is variola, dreaded on account of its violent symptoms, and known to have obliterated and cured numerous evils by means of the similitude of its symptoms; and it is a remarkable fact that inoculation with smallpox completely cured a protracted case of ophthalmia, as reported by Dezoteux (*Traite de l'Inoculation*, p. 189), and another case mentioned by Leroy (*Heilkunde fuer Muetter*, p. 384), which was also permanently cured.

Quoting from various writers, H. adduces an extensive list of cases cured by the intervention of smallpox. Thus, tinea capitis, deafness, swelling of the testicle, dysentery—all of which smallpox may produce and cure by virtue of its similitude. The same observations have been made in regard to cowpox, which, by virtue of the similitude of its secondary miasm, is capable of producing a certain kind of erythema, and cures similar and often troublesome cutaneous eruptions of children after the vaccination has properly taken effect. The same was observed in a case of swollen and half-paralyzed arm; also in those of intermittent fever in two persons as Hardege, Jr., reports (*Hufeland's Journal*, XXIII.), thereby confirming the observation of J. Hunter (*On Venereal Disease*, p. 4), that two fevers (being similar) could not exist at one time in the body (*Organon*, Sect. 46).

In the examples above quoted H. finds a strong support of his discovery of a law of cure, first by demonstrating that *dissimilar diseases* have that power, and, hence, continues H. (Sect.

47), "the preceding examples contain the most distinct and convincing argument in regard to the kind of artificial morbid potency (medicine) to be chosen by the physician in order to accomplish rapid and permanent cures, according to the process observed in the course of nature, *i. e., from a morbid potency which is similar in symptoms, and somewhat superior in strength*" (Sect. 48).

Such examples are not without interest, but of very little positive value unless supported by experimental tests of high order. The methods of such tests are now being developed at the hands of the ablest observers of our time, and it cannot escape even a superficial observer that there exists a remarkable analogy between the clinical results collected by H. and those obtained from the toxines of to-day.

But the momentous question arises as to whether H. really did all that was necessary to establish and confirm a positively defined law of cure, and whether we are justified in resting upon that which one observer, however distinguished, was able to accomplish a century ago. This question is not approached by the bacteriological studies of to-day. These progress in another direction, which may in the end assist in demonstrating the existence of the law of similars, but, if so, it will be incidental and aside from the purpose of bacteriological research.

It was the prime object and purpose of H. to discover facts in support of his law, for which, so far as my knowledge goes, he made only one experiment; and it is to be regretted that, notwithstanding the undeveloped methods and means of his time, a keen observer and generalizer like H. did not think it worth while to pursue the subject further by direct experiment. This includes frequent repetition, comparison of numerous results, controlled by counter-tests, for these constitute the most important conditions for the elevation of any hypothesis to the value of a law.

Among H.'s subsequent provings there were many drugs, the effects of which in disease were known to be curative, such as aconite, belladonna, arsenic, etc. Inasmuch as their curative effects were demonstrated to be due to their similitude of effect, as disclosed by provings, these might also be considered as inductive experiments in support of the law of cure. But

there is much that tends to show that he did not make those provings for that purpose, regarding the law sufficiently substantiated by his single china test, and his clinical quotations from the writers quoted above.

In the course of twenty years, after the promulgation of *similia similibus curentur*, it gave rise to a voluminous homœopathic literature. This included among its publications chiefly clinical reports of cured cases. All those published in Germany and those translated from foreign languages between 1822 and 1858 were published by Dr. Th. J. Rueckert in five volumes, including a supplementary volume by Dr. F. G. Oehme, now of Roseburg, Oregon. This large clinical material has grown to immense proportions in the past thirty-seven years, but it has not been collected and arranged, as was done by that most industrious, learned and reliable writer. We point to these achievements with pride, and say to the world: Behold what homœopathy has done; what greater proof of its success can be demanded?

And yet a perfectly unbiased observer, eager to see only the actual causes and relations of things, with the ultimate purpose of placing homœopathy on a sound, unimpeachable basis—such an observer cannot fail to see that there is wanting a great and essential element, the absence of which invalidates to a large degree, if not wholly, our theory of clinical experience. This, to say it plainly, is only of partial and indirect value in the absence of any knowledge of the whole number of cases treated, or even of the number of the cases of a certain class.

In accordance with the commonest principles of statistics, both factors or classes, the negative as well as the positive, must be known if any valid and consistent proof of our method is to be furnished to the world. What would we think of a man arising in this assembly and stating that he had in thirty years of practice lost only five cases of pneumonia? In this instance the inference would be that he saved 100 per cent. of his cases. But precisely the inverse inference would be justified if he had asserted to have saved only five cases of pneumonia. Just so with regard to our or any other method of practice which publishes cures almost exclusively. These are received with marked approbation; but supposing the opposite were the case, and we

heard only of failures, what then? This course would be quite as good, or quite as bad as the first; for while the first might meet with our applause, and the second with the silence of our disapproval, both instances, being equally unqualified, would be equally untrustworthy and of doubtful value. Such statements by one or by many individuals, would undoubtedly be at once met by the question as to the whole number of cases treated; by withholding this knowledge we have no very firm ground to stand on.

It is true that we have some fragmentary statistics, to which I have referred elsewhere (*HAHNEMANNIAN MONTHLY*, October, 1885), but plead that we must have more, and I hope to show presently how to obtain them. Hence, as far as I have proceeded in this very condensed review of the subject, the question propounded in the beginning must be answered in the negative, to the effect that the law of similars has not been unequivocally demonstrated, and that we require more formal proof by inductive experimental research, to establish it more firmly than has been the case hitherto.

The medical world at large has not accepted the law of similars. The negations of opponents are to be met, and the onus of furnishing evidence rests upon us. Without in the least underrating homeopathic practice with the means at our command, I would still urge that standing still without improving these means, is equivalent to going backward. Have we not stood still too long, and have we not too long been satisfied with the state of things as they have been for a century? With Hahnemann the healing art took a long step in advance, a century ago; if it will take another such step in the next hundred years, the world will have to rest satisfied for still another century to come.

This review would be purposeless if left unsupported by a plan of work by which to arrive at some tangible results, even if negative and uncertain. For more than ten years I have from time to time published suggestions tending toward an understanding of the subject, in the hope of stimulating some workers placed beyond the necessity of spending their time in the ordinary drudgery of professional life, and so far not entirely without success. Inquiries concerning my plans of work

I have answered\* in the following terms, setting forth our need of experimental investigation :

The human organism was selected by Hahnemann as the subject of experiment, but it unfortunately proves to be the most difficult and uncertain subject for that purpose. The ability to express sensations by language more or less eloquent is the very element leading to misconception and misconstruction. Instead of being the first, man should be the last subject of experiment in the final control-test, and be himself controlled. Effects obtained from animals under the influence of drugs, and their comparison with animals in health, would constitute fewer but more positive data in the form of symptoms; and these experiments should serve as control-tests for later tests made upon the human subject.

The subjects hitherto chosen by experimenters were taken from the canine-blooded animals, such as dogs, cats and guinea-pigs; but it is a matter of surprise that the omnivorous pig, being both prolific and obtainable, is not usually mentioned as a subject of experiment. Next to this, there is many a reason for the supposition that the lower orders, such as molluscs, articulates and vertebrates, chiefly frogs, but also insects and fishes, should not be of service, being both readily obtainable, easily kept, and observed in their natural element or conditions. Evidence is not wanting that these are quite susceptible of toxic effects, which are uniform and simple as compared with those obtained upon higher organisms; besides, they are more easily exposed to toxic influences of substances introduced into the elements or food needed by such animals.

It is often said by opponents of animal experiments, that these would furnish no reliable data applicable to man, but this is merely a general supposition unsupported by facts and by the experience of expert experimenters.†

As this short outline is not intended as a description of methods, I shall confine myself strictly to the statement of principles in answer to my original question. In order to approach this in the most direct manner, let me say that, while it is suf-

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\* *HAHNEMANNIAN MONTHLY*, June, 1887. "Aphorisms on the Methods of Proving," etc

† For information on this subject see *Text-Book of Experimental Toxicology*, by Dr. L. Hermann, Professor of Physiology at the University of Zurich.

ficiently well-known that drugs may produce morbid (pathological) conditions, that is, act as poisons, the amount of positive evidence proving the curative power of drugs is very small, barely deserving the name of a general deduction from clinical results, in which the whole number treated and the negative element of failures has never been duly considered.

*It is, therefore, necessary that the curative power of drugs should be as positively demonstrated as their power to produce morbid, i.e., pathological conditions, and first of all, it should be our object to determine experimentally whether it is possible to arrest or cure artificial disease produced by drugs (and other means) by the use of drugs as medicines. In other words, though we may know something concerning the production of artificial disease as practised in our provings, we have yet much to learn concerning it, but our chief aim should be to learn how to cure it artificially; that is, how to cause an animal to become diseased by means of drugs, and then how to cure it again of this drug-disease.*

This line of inductive research is to be distinguished from that followed by bacteriologists. This deals with the (toxine) effects of bacteria, while the course of procedure required by our therapy deals exclusively with drugs, and, therefore, will require separate and special methods of experiment. Again, while the bacteriologist pursues an indirect course in preparing his cultures, and resorts to the indirect process of producing disease through the medium of a living organism, generating a poison, the experimenter with drugs derives his results directly from these, by producing, and ultimately curing, artificial drug-disease.

The bacteriologist has the advantage in so far as he has succeeded in producing and curing artificial disease indirectly; may we equal him in this respect by direct drug-experiments.

In my article above quoted, a general outline has been given regarding the experimental course to be pursued; but to attempt to make special rules to be followed would be quite useless, because a person even slightly acquainted with experimental studies in a new field will know of the difficulties sure to arise. They will be like those met by an explorer of a totally unknown region of the world. All he knows is the destination he hopes to reach, perhaps the North Pole, or the other side of Africa, but of the route he may have to take he knows nothing,

nor where it will ultimately lead him. What he desires to find or to prove is one thing; what he actually will find may be quite a different and wholly unexpected experience.

An explorer, whether of this Institute or of the world in general, will have to be one of genius, like a *Newton*, a *Hahnemann*, a *Pasteur*, a *Koch*; his must be youthful vigor, independence of means and of time, while we, who have to toil wearily at our calling, must watch and wait and learn.

There is one more important side of the topic to be considered—namely, that relating to deductions from general practice. These, though first in the question as formulated, I must briefly dwell upon last. In order to decide any scientific question, either by direct experiment or by deduction from general observation, in either case the first guiding principle is to collect numerous cases or instances, to classify them according to their negative or positive value; and having done this, the second step would be to determine which class predominates in the determination of the question to be solved. This predominance should be decidedly convincing as to numbers, and predominant instances of success or failure should also bear very satisfactory internal evidence of having been fairly arrived at.

Applying these maxims to the determination of clinical results as due or not due to the use of medicines, the material to be drawn upon for a decision is very defective, if not wanting altogether. This state of things exists chiefly for the reason that there are no available records of diseases or of cases of sickness treated without medicine or without interference of some kind, intended to influence the course of the disease. The so-called expectant examples of *Dietl*, though voluminous, were not strictly expectant enough. On the other hand, the cases treated with medicine and other measures intended to influence the course of the disease, in and out of hospitals, is overwhelmingly great. This applies as well to our homœopathic schools, as I have previously shown, where the positive and desirable results have been and are still collected and published, while we remain in ignorance of the main elements of knowledge on the subject—namely, the whole number of cases treated and the whole number of negative results, including deaths or failure to cure.

As in the discussion of the subject of direct inductive research, I shall have time only to state the lines upon which the question of clinical testimony and evidence hinges. Stated in its most concise form it is this: *In order to prove that a case has been cured by medicine, it is first to be shown conclusively that the case could not have recovered or have been shortened without the use of medicine.* Upon the presence or absence of such knowledge rests the whole question of superiority or inferiority of schools of medical practice, and the question of superiority of therapeutic methods within schools; upon it depends the solution of the useless and puerile feud between allopathy and homœopathy, regular and irregular practice. Instead of endeavoring to decide a purely scientific question on its merits, both sides have preferred creeds, dogmas and ethical questions to quarrel about, and to say that homœopaths were the only ones to cling to a creed is one of the absurdities growing out of the helplessness of densest ignorance.

I reproach neither men, time nor circumstances in stating the case as I have done, but I feel and share the disappointment at the want of harmony among doctors in general. Let others quarrel and ostracise as they please, but let us at least take a step toward a better state of things by insisting on correct scientific data. Whether homœopathy is right or wrong it will stand or fall, not as a creed, but as a question of knowledge, as a scientific problem, and must be subjected to the crucial test of modern times. I assume that it is willing to abide by such tests. If other antagonistic schools refuse to submit to them the fault will be theirs.

When we had no hospitals, an essential part of the required tests could not be applied; but now that we have them in respectable numbers, these hospitals would miss one of the most important reasons for their existence if, for example, they failed to institute means for solving the questions before us. Therefore, let it be resolved or ordered by this Institute, for instance, that all or a certain class of acute cases, say pneumonia or typhoids in these hospitals, should be observed for several years without any medicine whatever. Then, after having collected a fair number of hundreds of such cases, let the same class and number be treated medically, or simply compared with those which had been treated with medicines hitherto. This course,

if pursued in the hospitals of both schools, would furnish us with the information we have never possessed. Its value would be inestimable. It would teach us the difference between actual expectant treatment under modern nursing and the medicinal treatment of the old school. It is impossible to venture an opinion as to how this would appear as compared with the observations made in hospitals of our school, but it is time that such results were obtained.

Some objections might arise against this course for fear of endangering the patient, and many might not have the courage to try it, so that it will soon be discovered that it requires more courage *not* to dose than to give medicine. Why? Because it has become a medical habit to give every patient a dose of some kind, be it large or infinitesimal, allopathic or homœopathic. But when calmly and dispassionately considered the wonder is that physicians have the courage to give medicine at all. By whom and how is it guaranteed that a certain dose of medicine, great or infinitesimal, will cure, or if not, that it is just the right one and safe one? As medical science stands to-day, what we know is immeasurably overbalanced by what we do not know, and any method which is on the side of absolute safety is the best. We may not cure, but we were guilty of malpractice if the least harm resulted from prescribing medicine, while no harm can come from omitting it, not counting the few well-known exceptions. Such tests, and such only, would allay contention, by such tests the schools, or rather methods, of practice stand or fall. Otherwise partisanship, exclusion and intrigue will go on forever.

It is to the hospitals that we must look for aid on the one hand and to the physiological laboratory on the other, to test by direct experiment the law of similars. Private practice is useless in this respect, unless poor, hard-worked doctors find time to collate and compare their results. This cannot be looked for, but henceforth the superintendents, medical staffs and internes of our hospitals should be instructed how to keep such records, and to collate them intelligently. But here, also, time and strength fail, for there are no idle persons in our hospitals, and it is earnestly to be hoped that special offices be created for this very desirable end.

Let me dwell on the subject but a little longer, for in this

connection there are other secondary, though no less important, questions to be determined. We have schools within schools who have been fighting each other valiantly for a century with empty words. I mean in regard to the dose. This question can in time be determined by the same means, and incidentally, in the course of the same process, the main question: Does medicine cure, and if so, how? Let it go forth from this body that statistical evidence of a certain kind is wanted. Let the *American Institute of Homœopathy* indicate its wish and purpose by a resolution directed to all hospitals, not only of our school, but of all schools. Nothing will tend so well to put an end to antagonistic sects as the arbitrament of exact experiment, in order that our practice may rest on the knowledge of the physician and not on his belief.

Finally, to those who think they find in these arguments the seeds of heresy and a desire to belittle the work of homœopathy, and to those who, by following closely the footsteps of Hahnemann, think that their practice is perfect, and, finally, to those who point to my words as a proof of incapacity or want of success, I have only to say: Show me by proof, not by mere assertion, how much better you can do, or be silent. The same I have to say to the opponents of homœopathy. Until more work is done on both sides, the game is a drawn one between our school and its opponents, and, I may say, between contestants within our own walls.

The differences are reconcilable only in the way I have endeavored to indicate, at any rate never by assertions of superiority and partisan segregation.

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#### PNEUMONIA AND ITS ABORTIVE TREATMENT.

BY J. D. BURNS, M.D., GRUNDY CENTRE, IOWA.

(Read before the Hahnemann Association of Iowa, at Des Moines, Ia., May 14, 1896.)

THE great mortality in this disease, the prevalence of the disease, together with the importance I place on the *early treatment*, have seemed to me reason enough for the production of this paper.

When it is realized that there are more deaths from pneumonia than from any other one disease to which this climate is subject, it is at once shown to be of the greatest importance that the physician be on the alert and be properly armed and equipped to do battle whenever he comes in contact with this disease.

But how shall we become properly equipped to do battle with disease? The medical world is divided. The dominant school says, "There is no medical treatment for pneumonia." Very happily such pessimistic views are held only by those outside of the homœopathic branch of the profession.

It is in the treatment of pneumonia that homœopathy has won some of its brightest laurels, the average mortality being from one-half to two-thirds less than under other systems of medication. Indeed, the allopathic school has practically acknowledged to the world that it has no medical treatment to-day for pneumonia. It has said, "Our treatment is worse than useless. We will fold our arms and watch the patient either get well or die, whichever way the scale may tip."

Osler says: "Pneumonia is a self-limited disease, and runs its course uninfluenced in any way by medicine. It can neither be aborted nor cut short by any known means at our command. Even under the most unfavorable circumstances it will terminate abruptly and naturally without a dose of medicine having been administered." If I read aright, there is no doubt but that *patients* were *somewhat* influenced by medicine under the heroic method of treatment when the mortality in some years reached 55 per cent., and from that down to a standard of 35 per cent. If he had said, "incapable of being favorably influenced by allopathic medication" he would have been right in the sense in which he meant it. Of course, he ignores every system of medicine, and we must take him at his word; but unwittingly he stumbled on a *truth*, and that truth is this: medicine does not influence disease *per se* at all. Medicine can only influence the person who has the disease. It is not disease that is sick, but it is the person who has the disease that needs the doctor.

But it is alleged that pneumonia is an infectious disease. Because the "bug hunters" have found a bacillus in the sputa of a pneumonic patient, they reason *a priori* that, according to

the latest fad, pneumonia is infectious. "Seventy-five per cent. of all pneumonias occur between the first of December and the first of May, and it is by no means confined to the cold northwest, but is even more prevalent in some of the southern States." So that it is widespread; but in no case have I ever seen it alleged that A caught it from B. If it be an infectious disease it is certainly a model of behavior, the infectious principle remaining inactive without the prerequisite exposure.

"It can neither be aborted nor cut short by any known means at our command." I presume he told the naked truth when he said that. I shall find no fault with him on that score only to say: He is not posted; he is speaking for allopathy and not for homœopathy. I thank God and Hahnemann that I know that just the opposite of that is true, that a patient sick with pneumonia can be favorably influenced by medicine.

The diagnostic symptoms of pneumonia are so plain that nobody but a novice or an extremely careless person can make a mistake; therefore, I will not discuss the question. Acute primary pneumonia is all I shall consider in this paper.

Acute pneumonia is an acute inflammation of the tissue, the parenchyma of the lung. An inflammation of that tissue would only differ from an acute inflammation in any other tissue of the body by reason of a difference in the tissues affected; the process of inflammation is the same. Owing to the nature of the lung tissues the changes appear in an aggravated form. The soft spongy nature of the lung tissue, together with the extreme vascularity of the parts, are the factors that render inflammation of the lungs more dangerous than inflammation in any other tissue of the body, because of the facility with which the exudate, the product of inflammation, finds a lodgment in the tissue and because of the abundant exudate as a result of the extreme vascularity.

*The exudate is the dangerous element in all cases of pneumonia,* and just in proportion as we can control this exudate, just in that proportion can we influence the person who has the disease toward recovery in uncomplicated cases. I am aware that this idea will not be favorably received because authorities tell us there are many breakers in the way—dyspncea, carbonic acid poisoning, coma, heart-failure, etc. But do you notice that all these complications spring up *after* the exudation has taken place?

Virchow advanced the doctrine that connective-tissue cell proliferation is the primary step in the production of inflammation.

Conheim held that it was a change in the *vessel wall* that was the first noticeable deviation in *acute* inflammation, and the more acute the disease the more the vascular element predominates; the more slow or chronic the inflammation the greater the part played by the fixed cells. Not a few pathologists hold that the first step in the process of inflammation is nerve-shock, though it cannot be proven.

The following are about the steps, as they occur, as recognized by the leading pathologists, so far as I have had an opportunity to consult them. The first noticeable effect is a dilatation of the supplying arteries and arterioles, with an increase in the rapidity of the blood currents. This dilatation increases and extends to the capillaries and venous radicals. After a variable length of time the rapidity of the flow is diminished, owing to the changes that are going on on the inside of the vessel wall and in the blood and blood currents—the leucocytes, from their lesser specific gravity, being forced to the circumference of the stream and adhering to the vessel wall, piling up in convenient places, such as the bends of the vessels, this retardation being first observed in the veins, then in the capillaries, then in the arterioles, and finally in the arteries. This process occurs inversely to the preceding process of dilatation. As the stream becomes slower and slower the red blood-corpuscles apparently increase in numbers; the white corpuscles, being forced into the peripheral stream, adhere more and more to the vessel wall, form into layers, and finally the tube is completely occluded, so that all onward movement ceases and complete stasis results. The blood may remain fluid for a variable length of time, varying from a few hours to two or three days; but thrombosis results ultimately when the lining membrane of the vessel wall dies—a change in the vessel having gradually taken place during this time, which consists of softening of the cement substance which binds the nucleated endothelial cells together, and, as a consequence, separation of these cells occurs and small openings are formed in the vessel walls, called stomata, through which the vascular contents are extruded and which constitute the exudate of inflammation. This exudate may vary in its quality

and constituents all the way from serum to pure blood, according to the intensity of the destructive process, because the destruction of the vascular walls is in proportion to the intensity of the disease, together with the energy with which the columns of blood are pumped against the blood in the inflamed area.

Now, just in proportion as the exudate consists of blood plasma, red blood-disks and haematoblasts with serum, just in that proportion will it be difficult of absorption by the lymphatics, and just in that same proportion will the extensively destroyed vessel walls need repair before they can perform their function. But, in time, this exudate undergoes a change; when it gets ripe it coagulates, and by contraction of the fibrin in the exudate, drives out the watery elements or fluids and becomes a solid mass of exudate, when we say the lung is hepatised. In proportion as this exudate is rich in the solid constituents and blood plasma, it is incapable of absorption until it is again softened or liquified by nature's generous provision, at which time, if the patient is not too sick and exhausted, the exudate will be absorbed, and possibly the lung perfectly cleared up. But during this time changes will occur, owing to the presence of the foreign body in the interstices of the lung and the ferments arising from the heat of the body, so that the patient is very liable to become poisoned by the ptomaines to such an extent that recovery is impossible.

In the foregoing I have not attempted to reproduce or delineate the pathology of pneumonia as revealed by post-mortem; but have tried to follow the steps in inflammation to enable us, if possible, to find the *similimum* for its treatment.

The time to modify this exudate is at the beginning of the disease, even before it has taken place or while it is taking place. Can it be done? I say, Yes. It can be aborted, cured in the first stage in a large percentage of cases, provided the right treatment is begun early enough; or, if not cured in the first stage, the second stage will be shortened and its intensity so modified that resolution will take place in from three to seven days, being from four to eight days sooner than it would occur if left to nature's unaided efforts. I do not hesitate to say that, on the whole, pneumonia can be so treated as to rob it of its reputation of being "the greatest destroyer of life to-day known to the medical profession."

The first forty-eight hours after the chill is the time to make the impression, if at all; in fact, every moment wasted after the initiatory chill is precious time lost. The whole course of the disease is to be molded in the first two days, so that the earlier the treatment is begun the better.

Experience tells me that hygiene and environment are quite essential to a successful treatment. *Place the patient in bed* (an injunction *never* to be forgotten) in as roomy an apartment as possible, and keep the temperature steadily at 70° F. Allow a volume of fresh air to enter the room consistent with the keeping of an even temperature.

Moisture is essential both for the well-being and pleasure of the patient. If the patient be a robust male, no application to the chest is needed; but if the patient be a delicate female or a child, the chest should be enveloped in a jacket lined with raw cotton and smeared with lard or vaseline and well peppered with black pepper, and left there throughout the course of the disease. Perfect quiet should be enjoined and enforced if necessary. The diet should be of milk or some easily-digested fluid food. So far I think no one will go back on us; but the medical treatment, I think, is the great essential.

It seems obvious that to control the circulation is the great desideratum in the *first stage* of inflammation—to assist nature to restore a lost equilibrium in the circulation—and this is done by restoring tone to the blood-vessels. If this can only be partially done the case will be ameliorated in the same proportion.

This reasoning is in perfect harmony with the pathology of inflammation. *Veratrum viride* is the remedy, I think, that holds the first place as a medicine in the first stage of pneumonia, because the symptoms correspond to it. I expect some one is saying to himself and will say it to others, Pshaw! I have tried veratrum in all-sized doses, and I don't want it. I think I can see where such an one has made his mistake. Allow me to illustrate. I want to raise a pole, say 50 feet long, to the vertical position. I can apply a power that will raise it in one minute, and, if I can control the power perfectly, I can stop it when it gets to the exact vertical and all is well. But if I cannot control the power perfectly I had better take a little more time, and as it approaches the vertical go slow, lest I go too far and push it past the vertical and it falls the other way.

To my mind just such a condition exists in inflammation. The muscular tone of the blood-vessels is out of plumb, the equilibrium is lost in the vaso-motor nervous system. You wish to restore it. *Veratrum viride will do it.* But it will also paralyze it if too much is given. It is a two-edged sword and requires to be handled with care, and inasmuch as we cannot control the wave after it is once set in motion, care as to the size of the wave we set in motion should be exercised.

From the provings of *verat. vir.* we are told that: "It acts upon the cerebro-spinal system, especially upon the pneumogastric nerve, producing profound paralysis of the cerebro-spinal nerve-centres, the reflex motor nerve-centres, and of the whole circulatory apparatus, which results in intense congestion and inflammation of the brain and other organs, *especially* those under control of the pneumogastric nerve, *notably* the *lungs* and *stomach*. Thus the action of *veratrum* will be seen to differ from that of *belladonna* and other remedies which produce congestion, by excitation of the nerve-centres, rather than by paralysis." The whole difficulty is in getting the right effect. Just enough and not too much. Prudence always says, "keep off of the dead line." Some one will want to raise the pole at one lift and they will give five, ten or twenty drops of the tincture at a dose, and if the patient is a sturdy fellow, in two hours he will be better, and he will say: "That is a grand remedy, give me another dose." In another two hours he begins to think he does not feel quite so well, and in four to six hours he is perceptibly worse, still the dose is repeated, and in twenty-four hours the case is so aggravated (a genuine Hahnemannian aggravation), that the doctor fears the patient cannot live; in two days more he has passed over to the happy hunting ground. If the death certificate were rightly filled out, it would read: "Poisoned by *verat. vir.* from the doctor's stupidity."

Another one has gotten an inkling that there is danger in *verat.*, and he means to go a little slow; he will give one to three drops at frequent intervals until it brings the pulse down to sixty per minute, "and then hold it there." This can and may be done, and in many cases it will be all right, but in many more cases you will notice after a few hours the frequency of the pulse will increase, and then you will begin to increase the frequency, and possibly the size of the dose, and

wonder why the pulse should increase, the "sedative" having been continuously given. The next time the doctor comes the red face will have changed to a dusky face, and will continue to become more and more dusky and puffy until stupor and cyanosis are present, and death will soon close the scene. The same verdict as before—You have pushed the pole clear over. The entire vasomotor nervous system has been paralyzed.

Better go still slower and not try to cure your patient in one day, let the next cycle of time have a chance; we live by cycles of days, months and years, and we cannot do the work of two cycles in one without endangering the machinery.

When I say the first x dil., 15 to 30 drops in a half-glass of water, teaspoonful doses repeated every half to two hours, I am by no means arbitrary, but it is the happy medium I have found—that which will suit the greatest number of cases. Yet I find some who will do better on a higher dilution, but in my experience none will need lower. *You cannot give sedative doses of verat. vir. and continue it, in pneumonia, without aggravating the case.*

The next medicine is aconite, in the second dil. (2x). This remedy is not as frequently indicated as verat. in adults, in my opinion; but more frequently in children. The aconite patient, instead of being apathetic, is extremely nervous, agitated, uneasy, can't rest a minute in one place and afraid he is going to die. These two remedies, with special pain remedies, as bryonia, asclep. tub., chelid., codein, merc. and ipecac. will cover the field. Bryonia is a grand remedy; given at the time exudation is taking place, it will modify it greatly, even to say lessen it. If there is pleuritic complication *on the right side*, it will be especially valuable. Where the left side is affected, asclep. tub. would supplant it. Codein is a remedy for pain, which will not lock up the secretions, unequalled, but it will be very rarely needed when other remedies are judiciously used.

Sometimes the indications for merc. are prominent, such as profuse, strong, offensive perspiration without alleviation of suffering or physical signs; a yellow tongue, offensive breath, feeling of fulness and pain in the liver. I prefer merc. dulc. 1x, five to ten grains ever hour till five or six doses are given, then let it work.

If the pain is all centred under the right shoulder blade, with yellow sclerotics, chel. 3x, is *par excellence*, and your patient will think well of your choice. If there is persistent nausea with inability to vomit, ipecac. 1x to 3x fills the bill admirably.

Under this treatment, in twenty-four hours, you will see the temperature drop to 99 to 101, pulse to 72 to 90. The respiration easy and nearly or quite normal. The physical signs will all be better, and the same medicine continued at longer intervals, according to circumstances, for another cycle of time will, in from 25 to 40 per cent. of cases, put an end to the trouble, not by killing the patient, but by curing it; or if the case is not cured, it will be so decidedly modified that it is robbed of its terror.

If, however, two days have passed since the initiatory chill, as happens many times before you see the case, the probability is, that neither verat. or ac. will be of much, if any service, and often positively harmful, and had better not be given. Dependence will have to be placed in another set of remedies. Just here I find fer. phos. will take the place of verat. or ac. most admirably, and supported or supplanted by bryon., phos., tart. emet., ars., alb. or lach., etc., according to special indications, the cases may be landed on this side of the great river in numbers that would surprise those who claim "pneumonia is incapable of being favorably influenced by medicine."

There are cases where no medication will change the outcome. The citadel of life has been charged, and death is inevitable. These cases form a part of the average 8 per cent. mortality under homœopathic treatment.

In the last eight months I have treated twenty-six cases of pneumonia where the symptoms, in each and every case, amply justify the diagnosis. An analysis of these cases more than justify the claims made in this paper.

#### ANALYSIS.

Number of cases, 26; acute, 25; chronic, 1; croupous, 20; catarrhal, 6; adults, 19; ranging in age from eighteen to sixty-six years.

Of the adults 14 were males, 5 were females. The remaining 7 were children, ranging in age from seven months to five years. Of these 7, 2 had croupous pneumonia, 5 catarrhal.

In all the five cases of catarrhal pneumonia in children, resolution took place by lysis, varying from seven to fourteen days. In one case of croupous pneumonia in a child 3 years old, resolution by crisis took place on the fifth day, the other by lysis after the ninth day. All children recovered.

In eleven cases I was called within a few hours after the chill. *In seven of these cases we can say that the disease was aborted*, so that there was no fever after the second day. Of the other four, resolution took place by crisis, three on the fifth day and one on the seventh day. In eight cases I was called after forty-eight hours from the chill, varying from sixty hours to nine days.

Six were my own cases. Crises occurred as follows: one on the fifth day, one on the seventh day, two on eleventh day, one on the fourteenth day, and one died on the eleventh day of the disease, two days after treatment was begun. Of the two cases from other (old school) practitioners, one was chronic, of more than six months' standing, a female of 66 years, who died; the other, a female of 24 years, whom I saw first on the eleventh day after the initiatory chill, and who died on the twelfth or next day. The statistical table would then read as follows: Number of cases, 26; recoveries, 23; deaths, 3; mortality, 11.50 per cent. Number of cases where the disease was aborted, 7, or 26.95 per cent. of the whole number of cases, or 63.63 per cent. of the cases where the treatment was begun early and according to the claims of this paper. Number of cases where the disease was shortened, 4, or 36.36 per cent. of cases claimed under this paper.

Of course there is only a limited number of cases here exhibited, and it would be impossible for me to tell which way the percentage would run, up or down, if the number of cases was extended to the thousands; but from the light I have, I believe the claim that pneumonia cannot be cut short or aborted is not in accordance with homœopathic therapeutics, but rather that my claim that pneumonia can be cut short, cured in the first stage, is substantiated.

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**Apis** is indicated in acute nephritis where the urine is scanty or suppressed, with general œdema, sleepiness, lack of thirst, dry, irritable skin, suffocation on lying down, etc.

## HAHNEMANNIANA, No. 5.

BY THOMAS LINDSLEY BRADFORD, M.D., PHILADELPHIA, PA.

## THE SECOND WIFE.

THE lady whose portrait is presented was associated with the last eight years of the life of Hahnemann. After the death, in 1830, of the helpmate of his changeful life, the household moved on in the same even way and the "Blessed Father" continued his quiet days of study and meditation guided by his devoted daughters. But in the latter part of the year 1834 a French lady of many accomplishments and of artistic and literary tastes appeared in the little Saxon town on the Zittau, Melanie d'Hervilly, born in 1800, the daughter of a poor Saxon painter, and adopted by one of the leaders of the French revolution, M. Louis Jerome Gohier, President of the Directory in 1799. She took the name of Gohier and was known as Melanie d'Hervilly Gohier. She had been a woman of many artistic impulses. Albrecht, the biographer of Hahnemann, writes: "We purposely limit ourselves to the very little that we have in manuscript about Melanie. Melanie, who was a second Madame Dudevant in intellectual ability, had learned riding and swimming, and was passionately fond of these physical accomplishments. She possessed all kinds of guns and knew how to handle them in genuine sportsmanlike manner. She had been at the school of painting and had visited the dissecting room. On a visit to the Paris Bourse one day she learned that Hahnemann had been appointed President of the Medical Faculty of New York (no doubt the American diploma is here referred to). Then she immediately said to herself, 'Where this man lives I must go. I must investigate this.' This is her own language. Following her own inclination, she went most of the time in male attire. Hahnemann, who had strong moral views, could not approve of such conduct and opposed it. But how was he to help it? After their marriage they travelled as father and son from Coethen to Paris. She was wont to say, 'I prefer going about with men, for no sensible word can be addressed to a woman.' As a matter of curiosity, we find room for the following particulars. The father of Hahnemann's second wife was a painter from Saxony, who was blind and desti-



MADAME MELANIE HAHNEMANN, NÉE D'HERVILLY-GOHIER.



tute. Hahnemann took him to his home and cared for him. Her mother was severely afflicted with the gout."

She had a brother who was a merchant in New York. His daughter, M<sup>lle</sup> Louise d'Herville, for a long time kept a fashionable boarding school for young ladies in Philadelphia; she died on Saturday, April 27, 1895, in New Brunswick, N. J., aged 85 years. This lady had been a patient of both Drs. Lippe and Malcolm Macfarlan.

It was very common for artists to dress in male attire and was in no way considered derogatory to their personal reputation. It is said that Melanie went to Coethen thus dressed. There seemed to be mutual liking, which ended in a marriage between this old savant of 80 and this French lady of 35 years. It occurred on January 18, 1835, in a room of the house at Coethen. The bridal trip was to Leipsic, and there Hahnemann gave a farewell banquet to his pupils. His daughters went with the party. Madame Hahnemann wished to return to Paris, nor did Hahnemann seem to object. He made a will giving his property to his children, and on the first day of Whitsunside, 1835, he departed forever from peaceful Coethen, which had for so long been a haven of rest to him. His children and grandchildren went as far as Halle, where they dined at the Crown Prince; the children returned to Coethen and Hahnemann and his wife went to Paris. They reached that city the last of June or the first of July, 1835, and settled in a house near the Garden of Luxembourg, but soon removed to a larger and more elegant mansion at No. 1, Rue de Milan. Madame Hahnemann influenced the authorities so that Hahnemann was allowed to practice, and he did practice for the eight years of his life. Madame Hahnemann kept a fashionable household; they even went to the opera and theatre. She assisted him in his work and often prescribed for patients under his advice. After Hahnemann's death she, continuing to practice without a diploma, was arrested, and after a lawsuit she was compelled to pay a fine for illegal practice. There seems to have been no further trouble, although she continued to practice until her death. We have interesting accounts of the personality of this lady, and several of our American physicians visited her. She died of bronchial catarrh, like her husband, May 27, 1878, and was buried by his side at Montmartre Cemetery.

## TWO ODD MEDICAL RELICS.

BY FRANK H. PRITCHARD, M.D., WEAVER'S CORNERS, OHIO.

A FEW days ago, while treating a little girl who had stepped upon a nail, her mother related to me how a neighbor woman had advised her to treat the child's wound. Instead of applying any local measures, as the laity usually do to dangerous excess in such cases, it was to grease carefully the offending nail, and this done, to lay it away until the wound had healed. For the latter an ordinary rag was quite sufficient. This same treatment was said also to be excellent in wounds from an axe or any sharp-edged tool.

This curious advice at once called to my mind the old "Vaabensalve," "weapon-salve," of the ancient Danes, who, after being wounded, would not dress the wound itself, but use local remedies upon the spear or weapon which had caused the injury. Undoubtedly, the wound would do better with simple cleanliness than the hundred and one greasy mixtures of herbs and lard which represent to-day the domestic remedies of "ye olden time." Dr. Robley Dunglison, *History of Medicine*, Phila., 1872, p. 236, refers to a similar remedy, the Sympathetic Powder of Sir Kenelm Digby, Knight of Montpellier. Whenever any wound had been inflicted, this powder was applied to the weapon that had inflicted it, which was, moreover, covered with ointment, and dressed two or three times a day. He goes on to state that this practice is repeatedly alluded to by the poets. Thus, Sir Walter Scott, in the *Lay of the Last Minstrel*:

"But she had ta'en the broken lance,  
And washed it from the clotted gore,  
And salved the splinter o'er and o'er.  
William of Deloraine, in trance,  
When'er she turned it round and round,  
Twisted as she galled his wound.  
Then to her maidens she did say,  
That he should be whole man and sound."

Long after the seventeenth century the formularies contained an "armatory unguent," which was applied to the instrument. According to Lord Bacon, the wound was washed clean, and

then bound up close in fine linen, and no more dressing renewed until it was whole. Under such treatment it was of little importance what application was made to the instrument; binding up the wound, bringing the edges in apposition, defending it from extraneous irritants, and leaving it to the restorative power of Nature is a method of treating incised wounds that was in vogue during our pre-antiseptic era.

Dryden alludes to the superstition just referred to more than once in his *Tempest, or Enchanted Island*. Thus Miranda, when she enters with Hippolito's sword wrapt up :

HIP.—O, my wounds pain me.

(*She unwraps the sword*)

MIR.—I am come to ease you.

HIP.—Alas ! I feel the cold air comes to me ;

My wound shoots worse than ever.

(*She wipes and anoints the sword.*)

MIR.—Does it still grieve you ?

HIP.—Now methinks the's something just laid upon it.

MIR.—Do you find no ease ?

HIP.—Yes, yes ; upon the sudden all thié pain

Is leaving me. Sweet Heaven, how I am eased.

—Act V., Scene ii.

With access to a large library, one might find any amount of literature upon this interesting subject.

Now to the second musty old relic. We have all heard of pow-wows, and generally understand it to mean the treatment of a patient by an Indian medicine man. But among the Pennsylvania Germans it is a term given to a form of incantation or exorcism against disease in its varied forms. This method of treating disease dates, as one would imagine, from the earliest times, and is found or has been found among all nations at some time in their history. The pow-wowning amongst the Pennsylvania Germans is only the "Brauchen" of the Germans of the Vaterland, where it is still in use among the credulous and ignorant. Most all German peasants believe in it or have heard of it. The method of procedure is very simple. A person having the power of treating disease thus, repeats a fixed formula and makes a few mysterious strokes with the hands, and ends with naming the Trinity, Father, Son and Holy Ghost. Unalloyed faith is required for a cure. If it fail, you have not believed, so that the doctor has a large-sized hole for retreat in

case of failure and his reputation as a "pow-wower" is untarnished. There are certain formulas for certain diseases. I once collected a number, but I have mislaid my note-book and I cannot find it. For example, in erysipelas one seats himself in front of the patient, strokes the affected part and repeats the following: "Wildes Feuer, fliege weg, wie Kohlen in die Aesche." (Wild Fire, fly away like Coals into Ashes.) In case of burns the same formula is efficient if one substitute the word Brand-feuer (a burn from fire) for Wildes Feuer. I warn the male readers of this that all their efforts to manage erysipelas with this measure will fail, for to be a successful "pow-wower" these formulas must be learned from one of the other sex; thus a male can learn them from a female and a female from a male. If this rule be broken, the spell is broken and the remedy will be powerless.

For marasmus in children, take a cord of flax spun by a child under seven years and measure or bind it about the little patient's body in its different portions, and repeat the appropriate formula. This formula has been forgotten by me, and I can find no one who can recollect it. But in order to make some return, I will give you one for bots in horses: Rub your right hand three times over the horse's back towards his tail, repeating with each rub the following: "Die Maria geht durch das Land; sie hat drei Wuermen in der Hand; roth, weiss und gelb. Vater, Sohn und heiliger Geist." At the third repetition, accompanied with the proper stroke, strike the horse a smart spank over the root of his tail, and the deed is done. The worms will vacate.

I have an acquaintance who "pow-wows" for consumption and kindred ailments. I have now a patient with incipient phthisis, who announced to me the other day that he thought of discontinuing my drugs and emulsions for a time, to try his fortune under a "pow-wower" for chest disease. I also know of a young man who swears that he was cured of peritonitis by exorcism. In still another case a violent epistaxis which had resisted a physician's efforts was cured by a course of "pow-wowning." In case that one should not desire to commence experiments with such powerful formulas, one then might begin with a mild one such as this, which also did much good in the hands of a German exorcist:

"Wirst du gut, so bist du gut.  
Verreckst, dann bist verreckt."  
"(If you get well, then you are well.  
Croak you, then croaked you are.)"

This may all seem a laughing matter to some of my readers, but I assure that there are people in this land who firmly believe in this. Who doubts but that there are those who hold fast to Christian science? I said in my title that I had but two reliques of other centuries to present you, but I have such a good suggestion for practical service that I can not forbear jotting it down, that it go on record. One reads so much now-a-days in the German medical journals about this one's and that one's priority in calling the professional attention to a new serum, a new antipyretic or a microbe, that I wish to get this note in early —this preliminary communication (*Vorlaeufige Mittheilung*). We all have cases of measles to treat; we all have cases where the eruption will not bob up to the surface as it should. There are bryonia and ipecac which the books recommend here, but they do not mention my remedy. When all these milder measures fail, try it. Three years ago, during an epidemic of measles hereabouts, one of my neighbors recommended me to try it if occasion present itself. After all this preface "a longue haleine," as the French say, I will merely state the remedy is called "Nanny Berry Tea." It is made by gathering a convenient quantity of sheeps' dung, adding sufficient water thereto to make a thin decoction and allowing it to come to a boil. Then add sufficient sugar to sweeten. Administer it to the patient *ad libitum* and *ad nauseum*. Do not tell him the name of the drug until he has recovered his appetite and he is well, for it might derange his digestion.

While I am in this vein I will suggest the trial of a poultice of fresh cow's dung for stone bruises. In mumps, apply locally pigs' dung. It has done wonders in this malady; so I have been assured. In the mycotic stomatitis—thrush—of nursing children a measure, I have been informed, which had been employed before my services were called upon, was the local application of the child's freshly-passed urine. I can not recommend this latter remedy. I never saw it do good. The Germans of "the olden time" were partial to dung of various sources as a remedy. In the seventeenth century one good old writer even went so far as to compile a "Dreck-Pharmakopoea"—a Dung Pharmacopœia.

## THE DISADVANTAGES OF CIVILIZATION.

BY DOUGLAS CAULKINS, M.D., KNOXVILLE, TENN.

(The President's address before the State Homeopathic Medical Society of Tennessee.)

THE great law of compensation holds good in everything. As physicians we see its workings day by day. It does not require a philosopher or a sage to recognize its action. Civilization advances with gigantic strides, but hand-in-hand with civilization walks this uncompromising spectre. How are we as physicians concerned in this double stride, and what does it portend?

Glancing back fifty years along its track, we see the marvellous results of intellectual growth and development scattered in bewildering profusion on every side. The brain reels as it contemplates this magnificent array; but lurking in the shadow is a spectral figure, and its name is physical decadence. Our schools have attained a perfection well nigh incredible, the machinery moves without a jar, and we are justly proud of our magnificent public school system, but the youthful eye is giving way, and spectacles upon school children will soon be universal.

Look at the splendid system which characterizes the commercial and manufacturing interests of a modern city. Every man is a machine; each detail is performed with mathematical accuracy and precision, but neurasthenia has increased 50 per cent. in twenty years, and nerve tonics innumerable, of every shape, size, color, smell, and description, flood the market. How perfect and elaborate are the facilities for producing foods for the modern stomach, and yet dyspepsia was never so rife, and the dentist never so prosperous as now. So with every step upward in intellectual advancement, there is a step downward in physical excellence.

In a prehistoric burying ground recently discovered during the excavations for a railway in the Indian Territory, there were found three thousand skeletons of men killed in battle. A careful examination of these skeletons revealed the fact that every man had been a perfect physical specimen, not one of them less than six feet in height, and in all these three thou-

sand jaws there was not a single tooth decayed or missing, but the capacity of the skulls was not greater than that of the average five-year-old child of to-day. What a lesson is this for the nineteenth century physician. The intellect of a five-year-old and the form of a giant! Think you the women of that noble race had need for nursing bottles, or that the men had recourse to nerve tonics?

The problem for us as medical men to solve is threefold, involving the questions of food-reform, dress-reform and physical culture. The refining of flour is rapidly producing a race of boneless and bloodless men and women. The spectacle of an intelligent people deliberately eliminating from the staff of life its blood and bone element is one for the gods to weep over. A deglutinized and emasculated flour as the basis of a nation's food! Every physician in Christendom should make war upon this senseless and suicidal custom.

And what shall we say of the dress of the modern woman? What is the result of four generations of the corset? Why, the evolution of a beautiful waist, and a narrowing of the pelvic strait. The latest forceps figures are one in four, and the time is not far distant when the few and scattered puny sucklings that are ushered into the world will make their débüt under the auspices of that persuasive instrument.

Another much needed reform, second only in importance to that just mentioned, is in the modern foot-gear. The evolution of the shoe has been attended by lamentable results to the human foot. This cramped and misshapen member is crying aloud against the tyranny of fashion, but its cries are unheeded and the work goes on. The civilized toe has no individuality, but is merged, with its fellow-members, into an inert and distorted mass, covered with corns and writhing in the grasp of the ingrowing nail. There can be no grace of motion with such a foot, and the "pigeon-toe," together with the pleasing "hip-hitch," are the direct results of the tooth-pick, high-heeled monstrosities in which our highly-civilized pedal extremities are clothed.

A French scientist, recently writing upon the physical abuses of the day, estimates that, if the present tendencies continue, in a few generations walking will have become a lost art, and we shall have a race of legless men and women. We must

confess, that, though the picture may be overdrawn, it yet contains an element of truth. The multiplication of vehicles, in this age of steam and electricity, is nothing less than appalling. The keen competition in the race of life, which modern business methods have developed and fostered, renders the question of rapid transit one of paramount importance. The consequence is that the good old art of walking, which kept our forefathers strong of limb and sound of mind, has relapsed into a state of desuetude from which it is almost impossible to rescue it. It is true that the bicycle has, to some extent, taken its place, and that physical culture is receiving more or less attention in our universities and schools; but I think that you will agree with me—at least those of you who are not bicycle cranks—that nothing can take the place of walking in the muscular development of the lower extremities.

I would not have you think, because of this protest against modern abuses, that I would denounce, in *all* things, our modern civilization, or that I would give an unqualified endorsement of the methods of living which obtain in the Marquesas Islands. But there are times when the disgust of modern living arises strong within me, and I yearn for the good old days when the earth was young, and man and nature walked hand-in-hand.

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#### INFANT FEEDING.

BY WALTER SANDS MILIS, M.D., NEW YORK CITY.

IT is with more than my usual diffidence that I offer a few words on this overworked and threadbare subject.

In December, 1894, it was my privilege to read before the Homœopathic Pedagogical Society of New York City a paper entitled "*The Daily Routine of the Infant to the Time of Weaning.*"\* In that paper I went into details in regard to the daily "Bath" and in regard to the "Dress" of the infant. I also spoke of the daily habit in regard to "Nursing" in part as follows, and I consider the rules there laid down of enough importance to quote them here:

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\* Published in the *North American Journal of Homœopathy*, November, 1895.

"The infant should be put to the breast seven or eight times in the twenty-four hours. It should be allowed to nurse from twenty to thirty minutes, and should increase in weight at least three ounces during that time. In the day-time two hours ought to intervene between the end of one nursing and the beginning of the next. The recommendation that baby should go from six to eight hours at night without being put to breast is theoretically correct. Practically, if we get two rests of four hours each we shall do remarkably well. There is one point to which I desire to call particular attention, and I have seen it mentioned but once. That is, *the baby should always be fed when in the semi-erect position; never when lying down.* Breast babies are in the proper position when the mother or wet-nurse is sitting up. Excepting, perhaps, occasionally at night, when the mother or nurse is too tired to sit up and nurse her baby, breast babies do very well in this regard; but bottle babies are too apt to be fed while lying down. The infant's stomach is so constructed that food is easily regurgitated, especially from the horizontal position. Therefore, babies fed in this position are unable either to get a sufficient amount of nourishment or to retain all that which they do get a sufficient length of time to have it absorbed. Again, the liver is relatively very large in the infant, and when baby is lying down encroaches upon the capacity of the stomach to such an extent that a sufficient quantity of food cannot be taken."

The question of the food to be given, and the care of the breasts or of the bottles, as the case may be, was not treated of in the paper mentioned above, and I will endeavor to supply the omission in this article.

The best food for the infant is the natural one—the mother's milk. Had this not been so, mother's milk would never have been provided. It is an undisputed fact that the best interests of the child demand that the mother feed it at her own breast. This has been proven by the comparative statistics of bottle-fed babies, wet-nursed babies and maternal-nursed babies. Babies fed artificially have a very high death-rate, babies nursed by the mother have a comparatively low one.

I also believe it to be to the best interests of the mother to nurse her offspring—best for her own physical well-being. Lactation is a physiological process, and its premature sup-

pression I believe to be responsible for many evil consequences later. It has been stated that women who have borne children, but who have not nursed them, are specially prone to cancer of the breasts. I would like some of our surgeons to investigate that question and report on it. An intimate relation exists between the mammary glands and the uterus. This relation is of advantage immediately after labor is completed, as putting the infant to the breast excites uterine contractions and acts as a preventive of post-partum haemorrhage. Later on, nursing assists in the gradual involution of the uterus and its return to its normal non-pregnant condition.

To prepare herself, the prospective mother should, towards the end of pregnancy, frequently bathe her breasts and nipples with cold water. This will harden them and make them less liable to become cracked and sore after the baby's arrival. If the nipples are inverted or undeveloped, as so many are from improper clothing, they should be manipulated with the fingers for ten or fifteen minutes several times a day in order to properly develop them.

The secretion of the breasts for the first few days is called *colostrum*. This is nature's laxative for the new-born and clears out its excretory organs. Later, when the milk begins to flow, baby is ready for it.

If for any reason the baby does not thrive properly at the maternal fount, we will have to search for an artificial substitute. Sometimes, on account of the mother's health, we are obliged to seek another food. No hard-and-fast rules can be laid down for making a change in the source of supply of the baby's nutrient, each case must be managed on its own merits. Severe acute illness in the mother occasionally makes it necessary for her to stop nursing the child, although not always. I have taken one nursing mother through a light attack of pneumonia, and another through a severe case of facial erysipelas without detriment to either mother or child.

My first choice for an artificial food is plain milk diluted with plain water, the proportion of water varying with the age of the child. If given at birth, I use three parts in four of water and one part milk. This proportion is varied from time to time until at the weaning age, or, say anywhere from twelve to eighteen months, we can use pure milk. Milk should form

a large portion of the diet all through childhood. When a bottle baby is weaned we simply stop the bottle, not the milk.

My second choice of an artificial food is condensed milk, diluted at first with eight times its bulk of water. In recommending condensed milk I fully appreciate the fact that I am recommending what is most strenuously opposed by many experts. The opinions of other observers, however, are of less value to me than the results of my own experience. I know that many babies do well on condensed milk. There are two reasons why, when possible, I use condensed milk—first, it can be bought fresh almost anywhere; second, it will keep in almost any place.

My third choice of an artificial food is malted milk. I believe it to be one of the best of the proprietary baby foods.

After that, if I have to search still further for a satisfactory substitute for the mother's milk, I try Lactated Food, Mellin's Food, Imperial Granum, and so on through a list too numerous to enumerate.

In making one's selection it must be borne in mind that what will agree with one infant will not with another. A physician may use his favorite food with a dozen infants, and then have to use some other preparation with the thirteenth. No artificial food can be used as a universal substitute for human milk, no artificial food can be universally condemned, despite the statements of opinionated men.

It should be unnecessary to add that absolute cleanliness is to be observed in caring for bottles and nipples. The best bottles to use are the flask-shaped, short-necked ones stamped on the outside with ounces and half-ounces for measuring the contents. The best nipples are the perfectly plain rubber ones. Bottles with patent devices are to be avoided. Nipples with tubes attached never should be used, because they never can be thoroughly cleaned.

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**SEPIA IN OPHTHALMIC DISORDERS.**—Sepia is especially adapted to those cases dependent upon uterine troubles; and in prescribing this drug great reliance should be placed upon these and other accessory symptoms. The *aggravation morning and evening*, and the *amelioration in the middle of the day*, are almost always present.—*Hom. Eye, Ear and Throat Journal*, April, 1896.

## A QUESTION OF DIAGNOSIS.

BY E. G. WHINNA, M.D., PHILADELPHIA.

How comparatively easy the practice of medicine would be, at least as far as the diagnosis of the disease is concerned, if our cases, as we find them in actual bedside practice, corresponded to the nicely cut and dried descriptions we find in our text-books. But such is not the case, and while the text-book descriptions may be the standard, practically we find that many of our cases have wandered so far from the straight and narrow way that even their own causative germs might fail to recognize them.

The following case occurred in my practice recently: On April 16th I was called to see Mrs. T., æt. 40, a large, stout woman, in bed with a temp. of  $105^{\circ}$ , pulse 80, respiration rather short and labored, but not over 18 or 20 per minute. The patient insisted that she had pneumonia.

She gave the following history and symptoms: For a week previous she had complained of great soreness and tenderness in the region of the stomach and upper part of abdomen, more particularly on the left side; was easily tired out and suffered from headache. At the time of my visit she complained of intense headaches, not relieved by hot or cold applications, tenderness in region of stomach, sharp stitching pains through left chest, worse on deep breathing or coughing. Cough was short, dry and hacking, with slight mucoid expectoration. Breathing was short on account of the pain experienced on deep breathing. On examination of the chest, the respiratory murmur was harsh, but no dulness could be detected on percussion.

She also complained of aching all over the body, but especially in her lower limbs; had no appetite, was thirsty, but drank little on account of the vomiting which followed. Tongue was heavily coated, white in centre with no edges; bowels constipated. I watched the case carefully for a day or two, and found that the temperature remained between  $104^{\circ}$  and  $105^{\circ}$ , pulse 80, respiration 18 to 20 per minute. The headache continued, cough was troublesome, expectoration became more profuse and slightly tinged with blood. Gradually the chest symptoms abated, and

the abdominal tenderness increased; the bowels became very loose, and control over them was entirely lost, so that liquid fecal matter ran from her into the bed almost continuously.

During this time she was mildly delirious, especially at night; imagined pigs were in the bed with her; went rooting all over the bed hunting for them; it never, however, assumed the violent type. On the seventh or eighth day of my attendance a slight eruption came upon her abdomen, and a diagnosis of typhoid fever was made. That night her temperature, which had remained steadily between 104° and 105°, dropped to 103°, the next day to 99°, and she became very weak, dull and stupid, wanting to sleep all the time and was aroused with considerable difficulty. Within the next day or two the temperature fell to 96.4°, and for the next six weeks never rose above 97.5°. The heart's action was very weak, pulse at times scarcely perceptible, requiring very free stimulation. The abdominal tenderness gradually grew less, and as her diet was increased her strength slowly returned, but even at this writing, three months from the beginning of the attack, she is still very weak and feeble.

The striking points in the case were the prominence of the chest symptoms at first, the continued high temperature, the subsidence of the chest symptoms, with the increase in the abdominal symptoms and the *long-continued sub-normal temperature*.

The question in my mind is, was my diagnosis correct?

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**THE ABSORPTION OF INORGANIC COMPOUNDS.**—Dr. Woltering has tested the ordinarily held theory of to-day with regard to the absorption of iron salts, i.e., that they are not absorbed, but find the sulphur compounds in the intestine and thus prevent the organic iron compounds in the food from forming combinations. If this theory be true, then the manganese compounds should act similarly, for they behave like the iron compounds in the presence of sulphuretted hydrogen. From a number of experiments on mice, rabbits and dogs, he has found that this is not the case. After having given the sulphate of iron with the food he found the liver to contain more iron than usual. From his experiments he concludes that the inorganic iron compounds are not absorbed with as much difficulty as is generally supposed. They are, on the contrary, taken up by the intestinal mucous membrane, conducted to the liver and changed into organic compounds, whence they go to aid formation of haemoglobin; the surplus passes off with the faeces.—*Hospitaltidende*, No. 19, 1896 [In fact the majority of practitioners of both the homeopathic and allopathic schools to-day prefer the inorganic iron compounds in practice, for they yield better results Dr. P. Jousset. *L'Art Medical*. No. 7, 1896, would advise the insoluble preparations and, above all ferrum metallicum or ferrum redactum, which he has found best tolerated by the stomach.—Eds.]

## CORRESPONDENCE.

## THE PREVENTION OF BLINDNESS.

TO THE EDITORS OF THE HAHNEMANNIAN MONTHLY:

An article has recently been given to the public entitled "The Prevention of Blindness," which is "issued by the authority of the State Board of Health of Pennsylvania," and in which the author, speaking of ophthalmia neonatorum, makes the following statement (the italics are his own):

"It is hardly too much to say that *no one should become blind from this disease*, not only because it is quite amenable to treatment, if this be instituted from the beginning, but because the disease itself can be prevented in most instances if those who have the care of the mother and child understand the nature of the affection."

"From the facts and figures above given it will be seen that this is simply another way of saying that *one-third of those who are now blind might have been saved from this calamity*."

An intemperate statement of a subject frequently does the cause advocated more harm than good.

It is very necessary that frequent and earnest efforts be made to impress upon the medical mind the dangers attendant upon infantile ophthalmia and the possibility of its prevention if suitable means be employed, and the very general success that follows judicious treatment of this otherwise much-dreaded malady. But when an official statement is made, backed up by the authority of a State Board of Health, it should be exactly stated in careful language or much harm may follow.

Now, while it is a fact that the purulent ophthalmia of infancy, when neglected or improperly cared for, often results in the loss of one or both of the eyes of the child, and while it is also true that there are few diseases that are more amenable to proper treatment, it is certainly not true that "*no one should become blind from this disease*."

The writer has a vivid and painful recollection of a feeble seven-month infant born with profuse suppuration of the conjunctivæ of both eyes, too asthenic to take the mother's milk

or to assimilate it, and soon becoming marasmic. The cornea of this babe, notwithstanding the most careful treatment, aided by the best counsel attainable, soon grew cloudy, then necrotic, and finally melted away, merely anticipating the like passing away of the child. No human treatment could have availed to save the eyes of a child in such a condition. Another case recently came under the observation of the writer, of a strong, well child, both of whose eyes were staphylomatous. The mother, a young society woman, had received a gonorrhœal infection from her husband during her pregnancy, and supposed that she was suffering merely from a leucorrhœa. When the baby was born an ophthalmologist of international fame was immediately called, and was untiring in his care; but, notwithstanding the fact that the case was important socially and financially and might possibly, although it is not probable, have received more careful attention than would a dispensary child, the result was hopeless and irremediable blindness.

A review of ophthalmic literature will show that conservative writers and careful observers are not as sanguine as the authority of the Pennsylvania State Board of Health. Noyes says :\*

"In bad cases the whole cornea may rapidly melt down, the iris extensively prolapse, the tissues rupture and the lens escape." "The length of treatment and the prognosis as to result are greatly influenced for good or bad by the health of the subject and by efficiency, as well as early commencement of the treatment."

Says De Schweinitz :†

"The prognosis is always grave, increasing in direct proportion to the violence of the inflammation and the condition of the cornea."

Fuchs‡ goes so far as to say that:

"If a case comes under treatment in season—that is, while the cornea is still intact—the latter can almost to a certainty be maintained in a healthy state."

But even this extreme statement is modified by the guarded "almost;" and while it is not disputed that it is a rare excep-

\* *Diseases of the Eye*, H. D. Noyes, 1891, page 303.

† *Diseases of the Eye*, G. E. De Schweinitz, 1892, page 224.

‡ *Text-Book of Ophthalmology*, Fuchs, 1892, page 57.

tion to meet with cases like those to which reference has been made, still there is no ophthalmic specialist of large experience who has not met them, and it is a severe, and it may be an unwarranted, stricture on the careful and intelligent treatment of the young practitioner who might have the misfortune to have in charge one of these virulent cases to have the asseveration authoritatively made by a State Board of Health that "no one should become blind from this disease."

It might be employed to his professional dishonor, it might give warrant to a suit for malpractice, that would result in discredit, no matter how cleverly or persistently his unavailing efforts were employed in his little patient's behalf. In the interest, then, of this important subject, in the interest of both the physician and his patient, and more especially in the interest of truth, this extravagant and intemperate statement should be modified and language employed which would be more scientific because more in accordance with an exact statement of fact.

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**SPONTANEOUS FRACTURES.**—Duems (Leipzig), has recently observed three cases of spontaneous fracture. The first was that of a girl of twenty-four years. She had danced the entire night and broke her femur as she attempted to pull off her tight shoe. The fracture was about in the middle of the femur. With extension and large doses of the iodide of potash healing took place uneventfully. The second case was observed in a very strong and muscular soldier, who in his first year of service received a slight push from a comrade and fell to the ground; on trying to rise he found it impossible. Here the fracture was between the middle and lower thirds of the femur, and the fragments formed a sharp angle anteriorly. Both cases presented, peculiarly enough, but very little pain at the seat of the fractures. In the latter case the patient, who was decidedly sensitive to puncture with a hypodermic needle, seemed to mind his fracture but little. In one and a half months consolidation had taken place, and in eight months he was able to be about. The shortening was two and a half inches. The third case was that of a male in the first year of military service. In marching back from a manoeuvre a double-quick was ordered over quite a stretch of bad road. As shortly before reaching the barracks the regular pace was resumed he felt an intense pain in his right thigh. He stepped out of the ranks, grasped a lamp post, and fell over. When seen immediately after he presented exquisite signs of a fracture of the neck of the femur. Healing took place uneventfully; in two months he was able to be about on crutches. The final shortening was two cms. In the sanitary reports of the German army in the years from 1882 to 1890 thirteen cases of spontaneous fracture are reported, and in all cases the femur was the bone affected. In the majority of such cases syphilis is the cause; not gummatous formation but general syphilitic atrophy. Anæmia from insufficient food, etc., also will cause it.—*Muenchener Medicinische Wochenschrift.*

EDITORIAL.

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## SUMMER OUTINGS.

IN studying the process of evolution in plants and in the lower animals we find in some the power of adapting themselves to the changes occurring in their environments, while in others evolution takes the form of developing new powers whereby they are enabled to escape from unsuitable surroundings to others more in harmony with their innate desires and requirements. By a not too great stretch of our imagination we can recognize the same difference in human beings in many respects, and perhaps in none so much as in the effect that our changing climate and altered social relations have produced in the matter of "summer outings."

Within our own conscious memory—which covers not quite half a century—a marked change has taken place. We well remember when comparatively few individuals or families, resident in cities, allowed themselves more than four or six weeks' summer outing. The vast majority of city-dwellers were content to remain there even during the dog-days and to mark their scant vacation by occasional excursions or picnics within a short radius of their homes. Then the seaside resorts were but few and the summer watering-places easily counted, while now the coast from Maine to Florida is scarcely long enough to accommodate the former, and the names of the latter fill pages of the daily press and overflow special editions of the railway guides. This supply has sprung up in answer to an imperative demand. In the building up of the cities, with the lessened amount of fresh air enjoyable and the greater amount of heat attainable, together with the restive expenditure of nervous force required by the competition marking every branch of industry, we see a justification for the demand and, in many cases, the necessity for change.

We see the millionaires running from Dan to Beersheba in their pursuit of suitable environment, now laving their monometallic toes in the surf of impartial old Ocean, now sneezing to the echo on mountain top, while there is hardly a factory

girl who does not think it necessary to recuperate in country or by the shore, even if it be at the cost of the most rigid economy practiced during the rest of the year.

On the other hand we find the hosts of "stay-at-homes," owing to their failure to develop the means of escaping their environments, compelled to adapt themselves to them. To what an extent they are able to do this a walk through the almost deserted streets and a visit to the alleys and by-ways of the cities during the dog-days will show. But with these we have at present nothing to do, nor with the social aspect of the tendency illustrated by the former class; but only as physicians with the question whether and how far these summer outings are of benefit. As formerly hosts of hopeful consumptives were sent to their death by the advice to go to Colorado without any discrimination of the requirements of each case, so now much harm is undoubtedly done by the want of individualizing in the advice to "go somewhere." It is very much the fad for every worn-out business man, every hysterical woman, every convalescent to expect to be sent away, and it frequently requires considerable persistence to convince one or the other that rest can in some cases be best found at home. Rest of mind and of body and the supplying and storing up of energy are the objects to be sought in every case, and only so far as they can be obtained by a change of environment is this to be recommended.

For diverting the mind and drawing off the attention from a morbid self-contemplation the life and gayety of the usual resorts are no doubt pleasant and effective means if used in moderation; but in cases where both body and mind are exhausted they become positively injurious by reason of the energy consumed in their enjoyment.

When, in the preparations for a summer outing, an excessive expenditure of mere physical energy is demanded from an already jaded and debilitated nature, the conditions will have to be exceptionally favorable if we are to hope for a good showing at the end of the season. If to the expenditure of mere physical energy there be superadded the pernicious attrition of pecuniary worries, in the endeavor to make a \$10,000 impression with a \$5000 income, or with three shirt waists and a grip to vie with the Saratoga trunk, then is the outing a delusion

and a snare, for which a temporary retreat to the back part of the house, with the front hermetically closed, with surreptitious nocturnal trolley rides, would be a hypocritical but beneficent substitute.

For the business man over whose head hangs from morning to night and night to morning, like the sword of Damocles, the railway time-table, coupled with the absence of those domesticities which have hitherto made his home a haven of rest, the benefits of the usual outing are problematical.

In all these cases and in most of the other customary ways of spending the vacation which could be cited we have change, it is true; but change, upon which so much stress is laid at present, is not all that is required. Change alone will never repair wasted energies, although it may call into play new ones while leaving time and opportunity for recuperation of the old. But are the conditions during the outing such as to call into play new energies? Are they not rather such as call for increased exercise of the very ones which have been in demand all the rest of the year?

It is not enough for those who need an outing to be told simply to go somewhere for the summer. The place where and the manner in which they are to spend the summer are of equal, if not greater, importance. In our experience the smaller number of those who flit away at the approach of warm weather in search of renewed health and strength return with hopes realized. It is only where rest has been selected like any other therapeutic measure with regard to the wants of each case that benefit can result.

In all cases the first essential prerequisite is that "black care" be left behind. Far better to remain at home and fight to the death with the accustomed weapons than to take it along and be hampered in our battle by unfavorable conditions.

An ocean voyage, perhaps, stands foremost on the list of recuperating agencies, although even here the fateful desire to break the record for speed is fast introducing an element of unrest.

Next comes a sojourn in the country, off the lines of summer travel, where the beauties of nature may slowly but surely lure the restive city soul to quiet. Then tours on foot or, better, on the bicycle, through unfrequented paths, with no

fixed itinerary—time was made for slaves—and no uncongenial thorn to puncture the tire of one's fresh enthusiasm.

For others new scenes reached by rail or stage or boat will prove almost a panacea, provided always that there be no inexorable "personal conductor" to apportion to each alike the measure of enjoyment allowed.

Last on the list we would place a sojourn at seaside or mountain resort, where the demands of fashion and the restrictions of conventionality almost entirely nullify the benefits to be derived from climate and scenery.

There are, therefore, outings and outings, and the only outing worthy the name is one in which all ruts of pleasures, as well as of business, are abandoned, and new energies and new faculties developed and the whole man built up in unshackled freedom to new strength and vigor.

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#### THE REVOLUTIONARY AND ANARCHISTIC MISSOURI STATE BOARD OF HEALTH.

WE desire to call the attention of all our readers to the open letter of the Hahnemann Medical College of Philadelphia to the Missouri State Board of Health, found on the *News* pages of this number. The letter really needs no comment upon our part, as it presents both sides of the controversy impartially and completely. The real friends of "State medical license" will read it with regret and will find it hard to appreciate the fatuity which has led the Missouri Board to attempt to abrogate and to divert to itself the prerogatives vested in the medical colleges by the various commonwealths of the United States, with the one exception of the selection of the trustees of these institutions.

The unparalleled presumption exhibited in this Missouri schedule of requirements of the medical colleges of the United States, coupled with the appalling threat of listing the disobedient and recalcitrant schools as "not in good standing," will do incalculable harm to the "State license movement."

At one fell swoop this revolutionary board would destroy all the safeguards that two centuries of experience has built up

around medical legislation in this country and set itself in its stead, and, in the smallness of its new and brief authority, it has made itself, by its demands, ridiculous in the sight of all conservative and well-thinking people.

The real and only work of a medical examiner is to test "the applicant for a license" and ascertain if he has sufficient information and training to enable him to practice medicine with safety to the public. It is not even his province to try to find out how much the applicant knows (this is none of his business), let alone trying to dictate to medical educators. It is probable, however, that there is not a medical examining board in existence which has not gone beyond the real limit of such a board, and efforts similar to this Missouri attempt will unquestionably bring State medical licensure into well-merited contempt, and will hasten the day of license abolition.

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#### THE ILLINOIS STATE BOARD OF HEALTH.\*

THE State Board of Health of Illinois, which in the past has done so much for the elevation of the standard of medical education in America, has also strayed away from its wise and conservative position of former years, and is now attempting to usurp certain rights, privileges and functions properly belonging to medical educational institutions. Its aggressiveness is not so pronounced nor as offensive as that exhibited by the Missouri board; but its trend is in the same direction, and it is well nigh time for the colleges to come to the defence of their rights or they will soon find that their authority has virtually been swept away from them.

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#### THE HOMOEOPATHIC MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA.

THE thirty-second annual session of the Homœopathic Medical Society of the State of Pennsylvania will be held at Phila-

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\* For letter, see *News* pages of this month.

adelphia, Tuesday and Wednesday, September 29th and 30th, and Thursday, October 1st, 1896, continuing in session until its official business and scientific work is completed. The date selected is later than customary for the last few years, the object being to avoid a repetition of the excessive heat experienced in Pittsburgh during the last session.

This being the century year of homœopathy, a committee of thirty of the most distinguished members of the Philadelphia profession are at work making special preparation to entertain the visiting members and guests of the society. There will be a large number of guests from outside the State, some coming from great distances; this fact of itself will stimulate a large attendance of members.

The secretary has in hand a programme of the scientific work that indicates that this meeting will be of unusual importance.

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#### A RIGHTEOUS DECISION.

On the 15th of July, 1896, the Supreme Court of Pennsylvania filed an opinion in Philadelphia in the celebrated case of Richards against Dr. L. H. Willard, of Allegheny City, in an action to recover damages for malpractice. This case was tried three times in the Pittsburg Common Pleas Court No. 3. The first time a verdict of \$5500 was rendered for the plaintiff. The jury disagreed the second time, and the third time a verdict for \$12,000, or \$2000 more than was asked, was rendered for the plaintiff. The verdict was reduced to \$4000 by the court below, but Dr. Willard refused to pay this and carried his case to the Supreme Court, and this court *reversed the case, dismissing the suit without granting a new trial.* (See *News* pages.)

This decision is a splendid vindication for Dr. Willard, and he is to be congratulated on his well-sustained defence in the attempt to rob him of his character and of his wealth, and the profession owes him a deep and lasting debt of gratitude, for we are all liable to exactly the same kind of dastardly attack, and his victory is our victory.

## ANOTHER AFFRONT.

ARE not the homœopaths making a mistake? That monument to Hahnemann in Washington will be a splendid thing artistically and an honor to the country, but are the builders wise to thus flaunt their prosperity in the faces of their hereditary foes, the "Regular" physicians? We have a deep sympathy for the latter. Nothing is more annoying to a good hater than the triumphant progress of those he has once decided to despise and ignore.

But the world was ever thus!

Hahnemann was the discoverer of a vital principle that has saved countless lives, but the old school of medicine would undoubtedly have been considerably happier if he had been quietly burned, or at least suppressed.

Such fellows as Archimedes, Columbus, Sir Isaac Newton, Hahnemann, Humboldt, and Ben. Franklin are sure to make enemies and to stir up trouble.

While we are ready to admit that the followers of Hahnemann save many lives where the Old School fails, we must protest against this wilful injury of the "Regulars'" sensibilities.

Imagine the feelings of George the Third if a statue of Washington had been deliberately erected beneath his royal nose!—*Life*, Fourth of July number, 705.

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SURGICAL TREATMENT OF EPILEPSY.—Peterson (New York) sums up the results of surgical treatment of epilepsy as follows:

1. In about 1 per cent. of all cases of epilepsy an injury to the head will be found to be the original cause.
2. In a much larger percentage an old meningeal haemorrhage, congenital or acquired in infancy, giving rise, in addition to the epilepsy, to various degrees of paralysis, idiocy, or other cerebral symptoms, and presenting, on examination, brain atrophy, sclerosis, and cysts as sequelæ to the primary lesion, will be ascertained to be the cause.
3. In the present state of our knowledge and experience, those cases due to meningeal hemorrhage should not be operated on at all.
4. In the very small number of cases having injury to the head as a cause the epileptic habit is so strong and the changes in the brain are usually so old and deep-seated that an operation, as a rule, does not cure and only seldom permanently diminishes the frequency of the attacks.
5. Of miscellaneous traumatic cases where a surgical procedure seems justifiable and is undertaken, cure may reasonably be expected in perhaps 4 out of every 100 cases operated upon.
6. The removal of a cicatrix from the cortex, supposed to be the epileptogenic nidus, will naturally be followed by the formation of a new cicatrix in the surgical wound, and is scarcely a defensible procedure.
7. The more recent the injury, the greater will be the promise of lasting benefit. If 100 cases of epilepsy could be selected in which the trauma dated but a few months back, trephining and ablation of the morbid tissues would doubtless prove curative in a large percentage of cases.—*New York Medical Journal*.

## GLEANINGS.

### GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D., AND FRANK H. PRITCHARD, M.D.

**A PROBABLE EXPLANATION OF THE DEATH OF DR. LANGERHAUS' SON.**—A full and satisfactory explanation of the sudden and tragic death of the little son of Dr. Langerhaus immediately following an injection of antitoxin serum has been reached through the subsequent investigation. In the first place, the analysis of the serum proved it to be reliable, and no irregularity in the method of its administration could be discovered. It was found, however, that the child had just completed an unusually heavy meal, and as the necropsy showed his larynx and trachea well filled with a material identical with that found in his stomach, the accepted inference is that while faint from the shock of the injection he was unable to eject the vomited matter from his throat, and instead drew it into the air-passages with fatal effect.

It may be concluded, then, that what appeared to be quite damaging evidence against the serum is really the result of a very simple accident.—*Medical News*, July 4, 1896.

**EPITHELIOMA OF THE DUODENAL ORIFICE OF THE PANCREATIC DUCT-AMPULLA OF VATER.**—Dr. Rendu has observed a man of 50 years who was neither alcoholic nor syphilitic, but who was attacked by jaundice absolutely unaccompanied by any pain. At three different times this jaundice disappeared without giving rise to any symptoms other than those of simple retention of bile; then it reappeared, accompanied by fever, painful tension of the liver and serious symptoms of infection resembling those of acute yellow atrophy. Death took place, associated during the last two days, with intestinal hemorrhage.

At the necropsy there was found a cylindrical epithelioma exactly limited to the ampulla of Vater, a suppurative angio-cholitis and multiple abscesses of the liver, while the pancreas itself was found to be entirely unaffected. He calls attention to the alternations of amelioration and aggravation in the course of the disease and the persistent diarrhea of the terminal period as distinguishing clinical features of cancers of the ampulla from those of the head of the pancreas. The beginning of the affection was insidious and remarkably benign; the growth undoubtedly did not completely occlude the duct, so that biliary obstruction was insensibly gradual, the growth of epithelioma being slow. In cancer of the head of the pancreas the neoplasm does not necessarily give rise immediately to icterus, but when the growth finally comes to compress the duct, the jaundice is definite and will not retrogress. Intermittence in the icterus is therefore a sign in favor of cancer of the ampulla, while persistence would point to cancer of the head of the pancreas, especially if joined with emaciation and signs of serious deterioration of the organism. The diarrhea is also an associated sign of epithelial cancers of the intestine, for whatever their site, they are usually accompanied by this symptom until other symptoms, as obstruction or hemorrhage, join to clear up the diagnosis. In chronic icterus from obstruction from gall-stone, constipation is the rule even when associated with angio-cholitis; though icterus may produce enterorrhagia, it will not cause diarrhea.—*La Semaine Médicale*, No. 23, 1896. [Prof. Hanot has recently observed a case of the same disease in a woman where the necropsy revealed a carcinoma of the ampulla of Vater. It was supposed to be one of the head of the pancreas, a disease with which it is frequently confounded. He directs attention to the slow course of the disease, its greater frequency than is generally supposed and the remission in the icterus for relapsing chronic jaundice in other conditions is very rare.—*La Semaine Médicale*, No. 22, 1896.—Eds.]

**THE ETIOLOGY OF SEROUS PLEURITIS.**—Dr. A. Aschoff, of Berlin, from a bacteriological investigation of 200 cases of serous pleuritis, concludes as follows:

The serous exudates are nearly all free from pus germs; if they contain such, with the exception of the pneumococcus, the disease goes on to empyema, which may occasionally be cured without an operation. It is very questionable whether an isolated rheumatic pleuritis is to be observed; those forms which appear together with acute articular rheumatism are connected with heart affections. Treatment with the salicyl-compounds is of no advantage in pleuritis. The idiopathic forms of pleuritis are nearly all tuberculous, yet they may be cured.—*Muenchener Med. Wochenschrift*, No. 14, 1891. [Prof. Osler, *Practice of Medicine*, 1-2, p. 559, says, "I confess that the more carefully I have studied the question, the larger does the proportion appear to be of primary pleurisies of tuberculous origin. The subsequent history of cases of acute pleurisy forces us to conclude that in at least two-thirds of the cases it is a curable affection. This may well be so, according to our present ideas of local tuberculous disease." The important rôle played by cold in the production of simple acute primary pleurisy he replaced by traumatism. *Ubi stimulus, ibi fluxus*, said the older physicians, and this doctrine may be applied to the infectious germs and their localizations.] Dr. A. Chauffard has published three illustrative cases.—*La Semaine Médicale*, No. 11, 1896. In these three cases of simple traumatic pleurisy, two developed distinctly tuberculous forms of the disease.—EDS.]

**PULMONARY TUBERCULOSIS IN HEART DISEASES.**—Dr. A. Weismayr reports six cases from V. Schroetter's clinic in Vienna, where pulmonary tuberculosis coexisted with a cardiac affection. In two there were mitral incompetency with stenosis of the venous orifice, twice aortic and mitral incompetency and twice aortic insufficiency. In four cases the tuberculosis had supervened upon a heart disease, which had pre-existed for a long time, while in the others the interrelation was difficult to determine. In three the tuberculosis pursued a rapid and, in the other three, a slow course. In spite of these exceptions, he is inclined to hold Rokitansky's theory as true; for, in spite of the immense number of necropsies done, the two diseases are very rarely met coexisting. The congested state of the lung renders the soil unfavorable for the development of the bacilli, and even if the tuberculosis develops it usually occurs slowly and almost without symptoms. The two cardiac orifices seem to behave in the same manner towards the disease. Apparently a combination of disease of several orifices has a still more inhibitive action upon the pulmonary affection. [Traube upheld this view and regarded stenosis of the left venous orifice as especially unfavorable for tuberculous development. Leber also advocated Rokitansky's doctrine. Tissier denied this immunity, but admitted that the tuberculosis was less virulent, more local and evoluted slowly. Potain, Renaut, Lépine and others saw in the pulmonary congestion the resistance to the tuberculosis process. Peter gave a somewhat different hypothesis: the bases being edematous, did not functionate; therefore, the apices being better aerated, acted better and were protected against the tuberculous invasion.—EDS.]

**NITROGLYCERINE IN ANGINA PECTORIS.**—Dr. Th. Schott claims that nitro-glycerine acts best in the pure forms of angio-spastic angina pectoris; next in similarity are cases where the cardiac spasm is associated with aortic incompetency. Much less reliable is the remedy in stenocardia from myocarditis, fatty heart as well as in "weakened heart." In anginose states from aortic aneurism its influence is usually but slight; in pure cardiac neuroses it will leave one wholly in the lurch. In no patient can one promise a certain result, for its action is individual, but it has the advantage of acting quickly, so that if indicated we soon discover it. In general, where toxic symptoms, as vomiting, attacks of fainting, etc., follow, it is better left alone. If the smaller doses are impotent and toxic symptoms do not result, then one may confidently increase the dose progressively. The form is also of importance, for he recommends the following: nitroglycerine (1:100, in alcoholic solution), 0.2; tinc. capsici, 2.5; spirit. rectificatissimi, aq. menth. piperita, ana, 12.5. Two five to ten drops, according to the nature of the case. Its rapid and astonishing results are soon seen in that the spasmotic state of the heart soon begins to yield, and in two to five minutes it has developed its full action. Frequently a few drops of this solution will quiet the attack. This is, however, not the rule, for after a small dose a larger one is usually necessary. In many cases a single large dose is successful. Though only a symptomatic remedy, it occupies a very important place in angina pectoris. [Dr. E. M. Hale, *Diseases of the Heart*, 1889, p. 27, speaks very highly of nitroglycerine in angina

pectoris. He holds to the views of Potain, Huchard, Hérard, etc., who look upon the disease as dependent upon an ischaemia of the bloodvessels of the heart muscle itself. This may be due to a spasm of the vaso-constrictor nerves of the myocardium or an ossification of the coronary arteries. Osler (*ibid.*) cites, among other views, that it may be a neuralgia of the cardiac nerves. Prof. P. Grocco, *La Settimana Medica*, Nos. 1, 2, 9, 14, 15, 1891, puts the pathology as follows: "There is a form of angina pectoris from anatomical or spasmotic stenosis of the coronary arteries, but there is a disturbance of the cardiac nerves. Again, there is a variety of breast-pang which consists essentially of a grave disturbance of cardiac innervation. Therefore, every angina pectoris is really a morbid manifestation of the cardiac nerves."—Eds.]

**DIAGNOSIS OF DISEASES OF THE INFERIOR VENA CAVA.**—Dr. Schlesinger at a recent meeting of the Vienna Medical Club, remarked that affections of the inferior vena cava are not necessarily productive of oedema of the lower extremities, oedema, etc. The oedema may be present only on one side, in particular where the iliac vein has been obstructed by a former phlebitis or by a thrombosis, where the vena cava is double, or where numerous veins collateral place the vena cava in communication with the iliac vein. In case of unilateral oedema to affirm that the vena cava is affected one should look to the collateral circulation. The signs pointing towards an occlusion are the presence of a double collateral circulation, renal symptoms, as haematuria, albuminuria and the signs of passive hyperæmia of the abdominal viscera, as varicocele of one side, etc.—*La Semaine Médicale*, No. 22, 1891. [I have seen a case of complete occlusion of the inferior vena cava where the lower extremities and especially the abdomen up to the diaphragm was covered with immense and tortuous veins varying in size from that of a needle to one's little finger. Patches of eczema with a varicose ulcer developed on one leg. The case was reported by my friend Dr Scudder, of Boston in the *Archives of Pediatrics* with plates, a few years ago. Occlusion is an occasional event in phlegmasia alba dolens. If life is continued, an immense dilatation of the veins of the body and thighs follows. The blood current is reversed, the stream flowing upwards through vessels anastomosing with the intercostal and internal mammary veins. Internally, the circulation is carried on chiefly by the azygos, which may become as large as the normal cava. There is usually, but not always, an extreme degree of ascites, together with anasarca of the lower half of the body. After a time, however, as the tributary circulation becomes established, the effusion will be reabsorbed. If the obstruction involve the portal vein, the ascites will be still more marked; in this case there is also enlargement of the spleen. When the cava is occluded above the point where it receives the renal veins congestion of the kidneys results, which in time produces interstitial changes. Yet here the establishment of the collateral circulation may be sufficiently prompt to avert the danger. I have seen a case of thrombosis of the femoral vein following typhoid fever where the thrombus undoubtedly extended up into the vein, thence into the vena cava. There was haematuria as an associated symptom. The patient recovered.—Eds.]

**CYCLIC ALBUMINURIA.**—Dr. Pierre Marie reports a case of this interesting disease where the albumen would appear in the urine as soon as the patient arose from bed to his feet or after violent emotion or storm. He finds the daily quantity of urine little altered; the specific gravity is at or above normal—1.020-1030; according to Tessier the urological cycle is: increased elimination of urinary pigments, albuminuria, and augmented excretion of urea. The disease is most frequently met with in males during adolescence and the first years of adult life. Heredity exercises an influence, and the descendants of gouty and arthritic parents are particularly prone to the disease. The writer regards it as a distinct morbid entity, which is purely functional and not dependent upon a nephritis. During a storm his patient would complain of a sort of pulsation in the region of the kidneys, a feeling of increased pressure in the upper portion of the chest, and a desire to breathe deeply. These he ascribes to a functional disturbance of the great sympathetic nerve. Hence these attacks appearing from barometric disturbance he denominates "renal migraine." Remedies exercising a sedative influence upon the sympathetic system would prevent or attenuate an albuminuric attack.—*La Settimana Medica*, No. 15, 1891. [Dr. Landi, "Albuminuria Ciclica," *Rivista Generale Italiana di Clinica Medica*, Nos. 18, 19, 1890, and Cesaretti, "Sul Rapporto Dell'Albuminuria Colla Circulazione Renale," *Rivista Italiana di Clinica*

*Medica*, Nos. 14, 15, 1891, have in a number of cases of this disease at the Medical Clinic at Pisa, studied the relations of this disease to various agents acting upon and influencing the renal epithelium and circulation. A compressive bandage around the loins was found to be the only certain and absolute means of bringing on an attack. Osler (*ibid.*) classes this disease under "albuminuria without coarse renal lesions." He lays particular stress, diagnostically, on its appearing after exertion, ingestion of food, and especially of proteids the absence of high pulse-tension and the lack of accentuation of the second aortic sound.—EDS.]

**THE FUTURE OF PLEURITIC SUBJECTS AND THE TUBERCULOUS ORIGIN OF PLEURISY.**—Prof. P. Jaccoud, in a recent lecture, asks the question whether one should regard every case of pleuritis as of tuberculous origin. He then proceeds to admit that there are cases of pleurisy where there is no doubt of the tuberculous base of the disease, as they are accompanied by tuberculous symptoms, and, again, there are those that are associated with pulmonary tuberculosis. In such cases one should keep in mind the heredity of the patient and the manner in which the disease began, for, with a tuberculous history and an insidious beginning, the disease is quite probably tuberculous. The speaker then takes up the statistics with regard to the development of pulmonary tuberculosis among pleuritics, which former, unfortunately, are variable and not wholly convincing. Yet they demonstrate that one may observe a tuberculous pleurisy in those without a tuberculous history, and, on the contrary, those with a pronounced tuberculous heredity may contract pleurisies which are not tuberculous. He finally concludes that it appears to him exaggerated to regard every pleuritic patient as threatened with death from tuberculosis; even in those who did, after several years, die of tuberculosis one cannot affirm absolutely that their pulmonary tuberculosis was due to that pleurisy. Indeed, after a pleurisy the lung remains more or less bound down by adhesions which hinder respiratory movement and expansion of the lung, so that such a patient without being tuberculous may be exposed to and contract the disease afterwards in consequence of poor functionality of the lung. Therefore, in pleuritics who have recovered from their disease one should prescribe appropriate hygienic measures.—*La Settimana Medica*, No. 14, 1891. [Osler (*ibid.*) divides tuberculous pleurisy into the following forms: 1. An acute affection accompanied by abundant sero-fibrinous fluid. In this category come certainly a proportion of the cases regarded as acute pleurisy from cold. 2. A subacute affection, latent in its origin and insidious in its course, frequently preceding the development of or coming on concurrently with pulmonary tuberculosis. 3. An acute pleurisy, the result of direct extension from the lung in cases of well-marked phthisis, and in which the fluid may be sero-fibrinous or purulent. 4. Chronic adhesive tuberculous pleurisy, which may be unilateral or bilateral, unaccompanied by exudation and characterized by great thickening of the pleural membranes, in which are tubercle and caseous masses of varying sizes.—EDS.]

**THYROJODIN, AN ORGANIC COMPOUND OF IODINE ISOLATED FROM THE THYROID GLAND, AN EFFICIENT REMEDY IN OBESITY.**—Dr. E. Baumann (*Muenchener Medicinische Wochenschrift*, No. 14, 1896) has succeeded in extracting the apparently active constituent of the thyroid gland, which he has found to be an organic compound of iodine. Dr. E. Grawitz (*ibid.*), of Berlin, has experimented with the remedy in a number of cases of obesity and found it to have a striking result in reducing flesh. With daily doses of 1 gramm he has seen a reduction of 3 kilogrammes in eight days without alteration of the usual diet. No disagreeable symptoms were noticed to accompany the use of the drug. Dr. A. Henning (*ibid.*) has also observed the striking influence of the remedy over obesity; in goitre and Basedow's disease no results worthy of notice were gained. In fleshy patients a reduction of 1 kilogramme a week was the rule, though a loss of 3½ to 5 kilogrammes was also seen. No restrictions were laid on the diet. Intercurrent affections, as coryza, influenza or appearance of menstruation, were contra-indications. The greatest decrease in weight was noticed in a woman of 32 years, who in twenty-three days lost 9.55 kilogrammes with absolutely no disturbances of health. Dr. Gottlieb (*Deutsche Medizinische Wochenschrift*, No. 15, 1896), from a series of experiments on thyrodecomized dogs, has concluded that thyrojodin is not capable of keeping the animals alive after extirpation of this gland, while, on the contrary, the fresh gland or an extract will do so. He claims that there are other active constituents in the thyroid.

## GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D., AND H. L. NORTHROP, M.D.

**CONSERVATIVE SURGERY IN THE TREATMENT OF HÆMORRHOIDS.**—Bacon (Chicago) calls a halt on "difficult surgical methods" and "operations which are attended with great risk either of life, incontinence, or loss of sensation of the anus," for the cure of hæmorrhoids. He condemns the reckless use of the Whitehead method and its offspring, the "American operation."

He calls attention to the anatomy of the rectum and the distribution of the hæmorrhoidal veins and proceeds: "A varicose condition of the hæmorrhoidal veins does not call for any different surgical process than for the cure of varicose veins in other parts of the body. Any operative procedure that destroys or interrupts the anastomosis of the venous plexuses, either of the external or internal, or intermediate veins, will, as a rule, relieve permanently the hæmorrhoids. Such an operation, as a thorough division of the sphincters, or massage of the varicosity, will cure many cases of hæmorrhoids that are of the internal variety."

Bacon says that there are certain principles that have governed surgery in the past and will continue to do so in the future. One of these is to ligate a bleeding vessel. Why should an exception be made in operating for hæmorrhoids?

A segment of the varicose system of veins must be removed. One segment on each side of the anus is sufficient. Therefore, if the larger tumors are removed, one at least on each side, the varicose system of veins is broken and the remaining varicosities are absorbed and disappear.

Remove those hæmorrhoids that are causing the discomfort together with the external, or skin tags, and the patient is cured, and only a small surface of skin or mucous membrane has been disturbed. The ligature, clamp and cautery, or crushing method, according to the choice of the surgeon, will answer the purpose.

After the patient is convalescent, teach him the causes of his previous trouble, and how to avoid congestion of his portal circulation, or over-straining of his general vascular system.—*International Journal of Surgery.*

**SURGICAL HINTS.**—Lead colic, with constipation, may simulate intestinal obstruction. Always ascertain the occupation of your patient.

An inflamed hemorrhoid will often cause exquisite pain. The little mass is bluish, hard and is with difficulty put back into the rectum, if, indeed, this be at all possible. The treatment is evacuation of the thrombus by a cut radiating from the centre of the anus. Relief is immediate.

Be very guarded in your prognosis in cases of injury at the elbow. A fracture into this joint treated with the most far-seeing precautions may be followed by more or less stiffness and disability. Begin passive motion as early as possible, delaying only long enough to allow the first pain and reaction from the injury to subside. In most cases this will allow some manipulation of the joint by the end of the first week.

Many a case of strangulated hernia has been overlooked, and the patient has been treated for colic, epididymitis, bubo and even for "idiopathic" peritonitis, until at last the almost fatal symptom of fecal vomiting appeared. It is wise in all cases of acute abdominal disease to examine for hernia, and, by the way, do not forget that this condition is not limited to the inguinal regions.

**IRRIGATION OF PUS JOINTS.**—Finney comments upon the uniformly unsatisfactory results of the old method of treating pyarthrosis, which was by aspiration or incision followed always by the insertion of drainage tubes. The final result of that operation was, in the most favorable cases, a stiff knee. In many there was a resection of the joint later, and in a large proportion of cases an amputation of the leg. In a case treated at Johns Hopkins Hospital a different plan was followed, at the suggestion of Halsted, with much success. The operation was, after applying a tourniquet to the thigh, to make a long incision into the joint on either side of the patella, through which the joint was irrigated with several gallons of 1:100 bichloride solution. Then the tourniquet was removed, the wounds covered with protective and treated in the ordinary way. There is little to be seen now except two parallel granulating wounds. The patient has been recently anæsthetized and the fibrous adhesions which had formed broken up.—*Journal American Medical Association.*

**WHAT ABSCESES MAY OPEN THROUGH THE UMBILICUS?**—Dr. Thorkild Rovsing, of Copenhagen, classes them as follows:

1. The so-called prevesical abscesses, which arise in the prevesical space and are most frequently due to extension of inflammation from the bladder; if they are not opened artificially burrow upwards and follow the remains of the urachus, perforate it and go outwards through the umbilicus.

2. The so-called sub-phrenic empyema or abscess, which may be dependent upon an inflammation extending through the pleura or have its origin in the liver, spleen or stomach, may extend along the ligamentum teres and perforate the umbilicus.

3. The most frequent is the perforation of intra-peritoneal abscesses or abscesses of intra-peritoneal organs. Thus not rarely an abscess of the liver or an echinococcus of that organ, as well as suppurative processes of the gall-bladder may penetrate there after previously having formed adhesions. In the same manner a gastric ulcer has given rise to an abscess which has perforated at the umbilicus. Stercoral abscesses from an umbilical hernia or an occluded intestine may also open in this region, but the feculent character of the pus will reveal its origin.

On the contrary, both acute and chronic forms of peritonitis not so very seldom perforate at the umbilicus. It is especially in children that peritoneal suppuration seeks this way out. These are usually dependent upon appendicitis. Tuberculous peritonitis in children during the suppurative stage has a tendency to penetrate at the navel.—*Hospitalstidende*.

**SUTURE OF WOUNDS OF THE ARTERIES.**—Heidenhain recommends the application of Schede's methods of suturing wounds of the veins to those of the arteries, and supports his view by describing an illustrative case. In 1894, while operating on a voluminous cancer of the breast, he accidentally made a longitudinal incision into the axillary artery, 1 cm. in length. He closed this wound for the time with three haemostatic forceps, and then united the edges with sutures of catgut. The haemostatic forceps were then removed, and the wound was found not to bleed, while the artery was permeable. The external wound was tamponed for two days and then united by a secondary suture. It healed without complication. Five months after the operation the patient's pulse was wholly normal, and there were absolutely no signs of aneurism. Two other cases are mentioned by the writer. In the first there was an arterio-venous aneurism of the femoral artery, while the second was a suture of the common iliac artery, which was done during the course of an operation on the intestines. In both cases a successful result was obtained. In doing suture of the arteries he recommends the employment of round needles and catgut, as well as to seek to obtain union by first intention rather than to tampon and to suture secondarily.—*La Semaine Médicale*.

**COLD ABSCESES OF GLANDULAR ORIGIN IN THE CERVICAL GLANDS WITH ALL THE CHARACTERISTICS OF GLANDULAR TUBERCULOSIS, BUT WITHOUT THE TUBERCLE-BACILLI BEING PRESENT.**—Dubard has recently observed three cases of cold abscesses originating in the cervical glands and varying in size from that of a nut to the volume of an egg, which abscesses presented all the characteristics of glandular tuberculosis, but where neither microscopic examination nor inoculation of animals revealed the tubercle-bacilli. The diagnosis of glandular tuberculosis seemed settled beyond a doubt, for the tumors both macroscopically and microscopically appeared characteristically tuberculous, yet the bacilli could not be detected under the microscope, and the inoculated animals remained unaffected. Therefore, he concludes that there are cases of pseudo-tuberculosis of the glands in which differential diagnosis is difficult without bacteriological examination and inoculation.—*La Semaine Médicale*.

**LOCAL ANESTHESIA BY SCHLEICH'S INFILTRATION METHOD—INFILTRATION ANESTHESIA.**—Schepens recommends this method in the performance of operations in minor surgery, it having as energetic an action anaesthetically as cocaine, and being devoid of its dangers. He advises the use of a formula first proposed by Würdemann: Muriate cocaine, 0.1; muriate morphine, .0 5; chloride sodium, .020; distilled water, 1<sup>00</sup>.0. This preparation is to be employed in normal tissues. Where the part to be operated on is painful one may increase the quantity of morphine and cocaine. A simple solution of cocaine of 1 per cent. will act best then. In operations on healthy tissues one may leave out the cocaine and use a solution of sea salt, 1 : 1000. The following are his conclusions:

1. An intracutaneous injection of distilled water is *very* painful, but it produces anaesthesia which lasts about one-quarter of an hour.
  2. The injection of a physiological solution of sea salt (6 per cent.) produces but little pain, yet the resulting anaesthesia is almost nothing.
  3. The injection of a solution of sea salt, 2:100, is but slightly painful, and the consequent anaesthesia is perfect.
  4. The injection of a solution intracutaneously discolors and renders the skin oedematous in a certain extent.
  5. The area of anaesthesia is limited to the infiltrated surface.
- The anaesthesia thus produced lasts about a quarter of an hour, but another injection will reproduce it.
6. The colder the injected fluid the greater the degree of anaesthesia. Solutions of 37° C. will anaesthetize but little.
- If an extended area is to be anaesthetized one may insert the needle at the edge of the previously infiltrated zone and thence infiltrate a further one.—*Journal Belge D'Homeopathie.*

**SPONTANEOUS FRACTURE.**—Erdheim recently communicated to the Vienna Medical Club two cases of spontaneous fracture. The first patient had had a phlegmon of the right leg following a contused wound, when suddenly he presented a spontaneous fracture of the femur of the same side. The hip was disarticulated and the bone was found eroded in consequence of a purulent osteomyelitis.

In the second case the spontaneous fracture of the femur was occasioned by a metastatic epithelioma. Here also disarticulation of the hip-joint was done. Later the patient presented signs of renal cancer—hematuria, renal pains, fever, etc.—the primary epithelioma being seated in the kidneys, with a secondary growth in the femur.—*La Semaine Médicale.*

**TREATMENT OF TRAUMATIC LESIONS OF THE LIVER.**—Schlatter, from his experience in a number of cases and a study of the literature with regard to the treatment of traumatic lesions of the liver, comes to the following conclusions:

1. Penetrating punctured and gunshot wounds of the liver require laparotomy as soon as possible in order to control the hemorrhage.
2. In case of suspected rupture of this organ the almost always fatal result of non-operative treatment justifies the surgeon in proposing laparotomy that he may control any hemorrhage, for the earlier the operation the better the prognosis.
3. The most efficacious means of controlling hemorrhage in hepatic wounds is suture of the liver, which in healthy hepatic tissue in adults may be easily and with certainty carried out. Deep parenchymatous sutures give the best results; these must be supplemented by suture of the capsule, which latter assist exact coaptation and supplement the deeper ones. The suture material should be thick and soft in order not to cut through; therefore the thick catgut is the best.
4. Only where the organ is lacerated or the wound inaccessible is tamponing or the thermo-cautery applicable.—*Hospitalstidende.*

**PoISONING BY IODOFORM-COLLODION.**—Borchgrevink records a case of poisoning from the use of a dressing of iodoform-collodion in an old man of 62 years who had been operated on for intestinal obstruction by laparotomy, and whose abdominal incision, 8 cms. in length, had been painted over with iodoform-collodion. From the third day an apathetic condition set in, which was followed by sleeplessness and delirium: on the same day an urticaria-like eruption appeared on his trunk and extremities, which was most pronounced around the wound. On the eighth day the dressing was removed, after which the symptoms retrogressed. Such an early appearance of the symptoms of poisoning generally only are to be observed in severe and fatal cases; that the slight quantity of the drug in the dressing was capable of giving rise to such decided symptoms is remarkable.—*Hospitalstidende.*

**PROBABLE ANEURISM OF THE INTERNAL CAROTID ARTERY.**—Oppenheim recently presented before the Berlin Medical Society a patient (male) who had suffered for fifteen years from violent headaches, accompanied by nausea and vomiting as well as a right bilateral hemianopia. The slow progress of his disease led him to suppose that the patient was suffering from an aneurism of the internal carotid or of some other encephalic artery. On auscultating the cranium one could detect a very pronounced murmur which was synchronous with his pulse and was especially audible in the left temporal region. On account of the rarity of

this souffle in adults he thinks it quite pathognomonic of aneurism of an artery in the interior of the cranium. As to prognosis it is well to remember that these tumors of the internal carotid may undergo spontaneous cure.—*La Semaine Médicale*.

**ON THE TREATMENT OF DEFECTS OF OSSEOUS SUBSTANCE.**—Neuber has frequently found difficulty in rendering as well as in maintaining his osseous cavities aseptic after operations for sequestra, etc., where the cavity is permitted to fill with a blood clot. In overcoming these difficulties he finds that by mixing the clot with an antiseptic substance he gets better results. He employs a mixture consisting of starch made into a paste with a little boiled distilled water which is then added to 200 grammes of a boiling 1 per cent. solution of carbolic acid. A glutinous mixture results, into which 10 grammes of iodoform are stirred. The fragments of suspected bone being removed, the cavity is well scraped so that all suspected bone is removed, irrigating finally with sterilized water. The operator then disinfects his hands, changes his instruments for others which have been freshly sterilized, dries the cavity and fills it with the iodoformized mixture. The soft parts are then united by sutures, a dressing is applied, the Esmarch bandage is loosened. The blood which then pours into the cavity mixes with the antiseptic and thus forms an antiseptic clot.

In cases thus operated on he has had prompt union in at least two-thirds.—*La Settimana Medica*.

**CAVERNOUS ANGIOMA ASSOCIATED WITH AN ARTERIO-VENOUS CIRCOID ANEURISM.**—Karewski recently showed before the Berlin Medical Society a patient affected with a very rare form of aneurismatic lesion. He had, in fact, a cavernous angioma of the right hand together with an arterio venous circoid aneurism of the forearm of the same side. At the age of 1 year he had vascular dilatations on his hand, which during the past four years had considerably increased in size and had led to trophic disturbances, multiple superficial necroses, suppuration and contracture of his hand. At present the dorsal and palmar portions of his right hand as well as the lower portion of his forearm were covered with a cavernous tissue which pulsated. The veins of his forearm were very much dilated, sinuous and gorged with blood. All the signs would disappear after he had held his arm elevated for some time in order to expel the venous blood, and the axillary had been carefully compressed, with care not to impinge at the same time upon the axillary vein. In such cases the prognosis is the most unfavorable. Amputation of the arm is the only resource.—*La Semaine Médicale*.

**THE STERILIZATION OF CATGUT.**—Hofmeister finds that formalin hardens the colloid substances of catgut that they will not dissolve in boiling water, so that this suture material, if first treated with thi-antiseptic, may be easily sterilized in boiling water without losing its resistency. He advises the following procedure in its sterilization:

1. Raw catgut rolled upon bobbins is allowed to harden for twenty-four hours in a 4 per cent. solution of formalin.
2. It is then boiled for ten minutes in water.
3. It is then hardened again and preserved in alcohol to which 5 per cent. of glycerine and 1 per cent. of bichloride of mercury or any other antiseptic in sufficient quantity is added.

It is necessary to boil the catgut on bobbins in order that it may not become tangled into a mass; at the same time it may be placed in the other solutions without much handling. Care must be taken to guard against bubbles of air becoming attached to the coils, thus preventing complete sterilization.—*Centralblatt fuer Chirurgie*, No. 9, 1896.

Dr. Hans Vollmer also speaks warmly of the disinfection of catgut with formalin. He recommends preserving catgut in a  $\frac{1}{2}$  per cent. solution of this antiseptic which has a great penetrating power as well as being powerfully antiseptic. As this drug is completely soluble in water, on using the suture material one may wash it off in distilled water or Tavel's physiological solution—chloride sodium, 7.0. carbonate sodium, 2.0. distilled water, 1000—thus obtaining an aseptic but not an antiseptic catgut. This latter solution may be used for preserving it aseptic. If one fears that it will not remain aseptic, one may allow the catgut to lie for twenty-four hours in a solution of formalin, dry the reels between blotting-paper and sterilize at a temperature of 60° C. Before using it should be moistened in a sterilized fluid. Catgut thus prepared is very resistant, pliable, will not tangle and may be tied with ease, while it will not be absorbed within fourteen days.—*La Settimana Medica*, No. 9, 1896.

## GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D.

**A NEW METHOD FOR THE LIGATION OF THE UTERINE ARTERY BY LAPAROTOMY—Altuchoff and Snegiroff.**—If the tube remains in position and the round ligament is drawn forward, the peritoneum between the two is drawn out nearly horizontal. Traction on the round ligament forwards also draws up on the so-called connective tissue mesentery of the round ligament, which is so intimately connected with the uterine artery that the latter is drawn up away from the ureter and uterine vein near the posterior layer of the broad ligament. This removes the danger of including either of the latter vessels in ligating the artery.

The technique of the operation is very simple. The abdomen is opened in the usual manner, and the round ligament drawn forward. The uterus and the tube are fixed in their ordinary positions. An incision three centimetres long and one centimetre from the innominate line is made close behind the round ligament and parallel to it, so as to open the anterior fold of the broad ligament. This gives access to the intraligamentary connective tissue. The incision is carried down twelve to sixteen mm., and a little nearer to the anterior than to the poster or layer of the broad ligament. The uterine artery will lie at the bottom of this incision and can now be ligated easily, as both the ureter and the uterine vein lie lower down on the posterior peritoneal layer of the ligament. After the uterine arteries, the plexus pampiniformis and the round ligaments are tied on both sides, the uterus and adnexa can be easily removed without fear of haemorrhage.—*Monatschrl. f. Geburts. u. Gynak.*, June, 1895.

**THE RADICAL OPERATION FOR INFLAMMATOY DISEASES OF THE APPENDAGES**—Bliesener from the clinic of Prof. Bardenheuer, at Cologne. In general, when the adnexa are so diseased as to require removal, the uterus must be extirpated at the same time. The most important indication is the presence of inflamed adnexa, which cause suffering which is not relieved by prolonged palliative treatment. In general, it is assumed that a tube enlarged to the size of the finger will not return to normal conditions. Any ascertainable collection of pus in the adnexa is a further indication for their removal. This last indication has been considered an absolute indication for many years. The material at the clinic is either the working class or prostitutes, in either of which a collection of pus is a serious menace to health. Bardenheuer formerly treated fresh inflammations or recent attacks conservatively, and did not operate till the acute symptoms subsided. Now he does not wait on the average over a week, and operates while the adhesions are still oedematous and easily separated. If there is no suppuration of the appendages, the operation is determined by the ability of the patient to work rather than by the local conditions. The proportion of these to purulent cases in 1895 was as 1 to 4. No operations are performed on hysterical patients unless distinct alterations of the genitalia are present.

There are also indications for extirpation of the uterus after previous removal of the appendages, such as profuse haemorrhages, sometimes regular or of a menstrual type; obstinate leucorrhœa; malpositions, often associated with abnormal sensitiveness of the uterus; or the symptoms may be due to parts of the adnexa left behind, to stumps of tubes, or to suppuration, or to exudation about them. The latter may be due to pus flowing out on the peritoneum at the time of the operation, which may become encapsulated in a peritoneal fold.—*Monatschrift für Geburtshilfe und Gynäkologie*, June, 1895.

**CLINICAL OBSERVATIONS ON ECLAMPSIA—Knapp.**—The severity of an attack can be measured only by its danger to life, which is best observed by its influence on respiration and on the heart's action. The more complete arrest of respiration at the height of the attack, with a high degree of cyanosis, and a bad quality of the pulse, are the best measurements of severity. In the majority of cases at the time of the convulsion, there is a high degree of cyanosis, the carotids pulsate strongly and both the superficial and deep veins of the neck are much distended. The frequency of the pulse is not usually altered materially (80 : 100 beats). The pulse during the convulsion is often small, in the interim tense, full and regular. In our experience a pulse over 100 (120 and thereabouts) is an unfavorable symp-

tom. Complete cessation of respiration at the height of the convulsion has not been observed by the writer. No reliable prognosis can be given from the condition of the urine. Prognosis must be very guarded if nephritis is already present. All women with oedema have albumin in the urine. The Prague clinic has a mortality of 8.3 per cent. for the mothers and 7.9 per cent. for the children, very low in comparison with other clinics. The chief rule for treatment of eclampsia in this clinic is to deliver carefully, but as quickly as possible, with the exception of a few cases which can be treated symptomatically. Even the slightest operations must be done under anaesthesia. In 47 per cent. of the cases the convulsions ceased after delivery. The anaesthetic used for both obstetrical and gynaecological operations is Billroth's mixture of three parts of chloroform, one of ether and one of alcohol. Next in importance to this anaesthetic, and almost as much used, is chloral hydrate; morphine is also employed. Protracted warm baths and warm, moist packs are also employed. Lukewarm milk is the only drink allowed. Frequent and copious movements of the bowels also materially improve the condition.—*Monatsschrift für Geburtshilfe und Gynakologie*, June, 1896.

**THE ARTIFICIAL DILATATION OF THE CONTRACTED PELVIS—Poeth.**—The anterior bony ring of the pelvis is laid bare by a transverse incision from above, and the soft parts are separated from it and protected by aseptic towels. The symphysis and pubic arch is split with a chisel in two pieces, or layers, an anterior and posterior. The posterior layer is divided at the symphysis with a probe-pointed bistoury, following which the pelvic bones separate or gape at the symphysis. The child is then delivered. The symphysis is allowed to gape, and the aperture is closed anteriorly by the plate of the bone which has been chiseled off the anterior portion of the pubic arch. The bone is fastened in its new position with heavy silk sutures and the skin wound is closed. The pelvis is immobilized by a compression bandage and supported by sand pillows. The operation is only suited to the minor degree of pelvic contraction.—*Ibid.*

**THE DIAGNOSIS OF SARCOMA OF THE ENDOMETRIUM.—Emanuel** finds the surest criterion for sarcoma of the endometrium in a histological sense is the presence of giant cells which are found in all forms of these tumors, but most often in round-celled sarcomas. The giant cells might be confounded with the giant cells of tuberculosis, but the well-known characteristics of the latter will distinguish them. If the giant cells are found round or spindle-celled tissues there will be no mistake made in diagnosing sarcoma, even if clinical conditions and observations fail. In the clinic of J. Veit the presence of very small round cells are not considered as in any way warranting the diagnosis of sarcoma, but if in the sections there are multi-nucleated giant cells sarcoma of the endometrium is diagnosed.—*Zeitschrift für Geburtshilfe n. Gynakologie*, vol. xxxiv, H. 1, 1895.

## OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

**DISEASES OF THE EYE DEPENDENT UPON INFLUENZA.—Dr. Povley summarizes as follows :**

1. The eye complications following grippe are comparatively rare.
2. Many of the cases reported as due to the grippe need more proof.
3. Grippe may affect the eye by inflammatory process or by invasion of the secondary sinuses.
4. It may affect the nervous tissues.
5. The inflammatory affections involve especially the conjunctiva, the uveal tract, tissues of the orbit, and the capsule of Tenon.
6. In some of these cases the extension is by continuity, and in others by metastatic or embolic processes.
7. The nervous apparatus of the eye is especially liable to become involved by paresis of accommodation or of the extrinsic muscles of the cervical sympathetic, by papillitis and retrobulbar neuritis, and anesthesia of the cornea.—*American Journal of Ophthalmology*, May, 1896.

**EUCAINE AS A LOCAL ANESTHETIC.**—Dr. Gaetano Vinci, of Messina ('D.R. Med. Zg.', April 27th), has experimented, both in the laboratory and clinically, with two forms of eucaine hydrochloride—that crystallized from a watery solution and that crystallized from a methyl-alcohol solution. A solution of from 2 to 5 per cent., instilled into the eye of an animal, such as a dog or a rabbit, caused complete local anesthesia in from one to three minutes. It began in the cornea, and spread thence to the conjunctiva, and lasted on an average from ten to twenty minutes. It was readily prolonged by repeating the dose. It was always accompanied by a slight hyperæmia and slight irritation of the palpebral conjunctiva. This, however, was the case only with the methyl-alcohol form; the watery solution caused at most a very slight hyperæmia. The pupil was not dilated and reacted well to light. Injected under the skin, eucaine caused complete anesthesia of the parts so that a reflex could not be evoked even with a needle. A similar complete local anesthesia of a mucous surface was effected when a eucaine solution was painted over it.

The general action of the drug, both in cold-blooded and in warm-blooded animals, consisted in a marked excitation of the entire central nervous system, followed by paralysis when toxic doses were given, going on to death. Even one thirty-third of a grain caused irritability, heightened reflexes, inco-ordination and finally general paralysis in the animals experimented with. Small doses administered to mice and rabbits caused increased reflex excitability, and increased but weakened respiratory movements. Medium doses of from a third to a half of a grain to each thirty five ounces of the animal's weight caused repeated tonic and clonic convulsions. The animals lay senseless on their sides, with dyspnoea, opisthotonus and finally paresis of the posterior limbs. These phenomena were most marked when large toxic doses were administered; the convulsions returned continuously and affected all the muscles of the body. The animals finally died when the paralysis reached the respiratory muscles. When the dose was not a fatal one the convulsions gradually ceased, the increased reflex excitability disappeared, and the paresis of the hind limbs slowly improved.

The author concludes that the effect of eucaine on the central nervous system is therefore at first excitant, and then, in the case of toxic doses, paralyzing. The paralysis is a central one, for if the sciatic nerve of a frog poisoned with eucaine is exposed and its peripheral end irritated with the induced current, the limb reacts in a normal manner.

As regards its action on the heart and the bloodvessels, the subcutaneous and intravenous injection of small and medium doses slows the heart's action on the average from twenty to thirty beats a minute, but without otherwise modifying the beats or increasing the blood pressure. This effect on the pulse is caused by the excitation of the central vagus; for section of the vagi causes an immediate increase of the pulse to the normal and above it, together with an increase of the blood pressure. Death occurs from paralysis of the respiratory centres, for the heart continues to beat for some time thereafter.

In all these points, says Dr. Vinci, eucaine is similar, physiologically, to cocaine. Yet there are some important differences which must not be forgotten. In the first place, eucaine is less poisonous than cocaine. While the animals treated with eucaine survived, those injected with the same doses of cocaine died. The pulse with eucaine is always decreased in frequency; with cocaine there is a primary acceleration. As regards their local action, the promptness of the anesthesia, and its duration and intensity, there is no difference between the two substances. But eucaine causes no ischæmia; on the contrary, vascular dilatation occurs. A further difference is that the pupils are not affected; mydriasis does not occur, and the reaction to light remains normal.

Clinically, both preparations were employed in 2-per-cent. solution and compared with similar cocaine applications. They showed that the two drugs were of like value in the human subject also, as regarded the rapidity, duration and intensity of the anesthesia. This is complete, progresses from the cornea to the conjunctiva, appears in from two to five minutes after the instillation, and lasts from ten to fifteen minutes. There is some hyperæmia, and there is slight irritation of the palpebral conjunctiva. Some patients complained of a slight transitory burning, but only when the methyl-alcohol preparation was used. The watery solution caused no effects save a slight, hardly noticeable hyperæmia. It is, therefore, the solution to be preferred for practical use.

Another difference of great importance was that eucaine did not, like cocaine,

induce mydriasis and paralysis of accommodation. The pupil was not distended at all, and reacted well to light, and the accommodation remained normal.

This was a property of the greatest importance in practical ophthalmology and favored the employment of eucaine in cases in which a production of ischemia with the anesthesia was not required. In violent inflammatory conditions of the eye, eucaine also promptly produced anesthesia, but the ischemic action failed, and consequently for such cases cocaine would have the preference. Both drugs diminished the intra-ocular pressure about equally.

Its last advantage was that the eucaine solutions were permanent and did not, like those of cocaine, decompose when kept. Cocaine solutions were decomposed when they were boiled for the purpose of sterilization, thereby losing their property as a local anesthetic, and the decomposition products had an irritant effect if such a solution was employed. Solutions of eucaine, on the other hand, did not suffer decomposition even when boiled for a long time.

Eucaine had thus been shown by experimentation on animals and on the human subject to have very marked local anaesthetic properties which rendered it worthy of being placed by the side of cocaine in ophthalmological practice.—*N. Y. Med. Journal*, June 20, 1896.

**TREATMENT OF GRANULAR OPHTHALMIA BY LIQUID VASELIN AND IODINE.**—Neznamoff, of Kharkoff, in cases of granular eyelids, paints the mucous membrane twice daily with a solution of pure iodine mixed with liquid vaselin, which is also called "oil of vaselin" (*oleum petrolei*). In chronic forms, as cicatrices from granular ophthalmia with pannus, infiltrations and superficial opacities of the cornea, he employs liquid vaselin containing one-half to one per cent. of iodine. By the third or fourth day a great improvement is visible; at the end of two or three weeks the vessels of the pannus become obliterated, the effusions are reabsorbed, the cornea regains its transparency, the palpebral mucous membrane becomes smoother and softer, and in consequence the sight improves. The so-called "fleshy pannus" (*pannus crassus*) will yield with great rapidity to applications of oil of vaselin containing  $\frac{1}{2}$  per cent. of iodine. Thus, in a case where two-thirds of both cornea were covered by a pannus at least half a millimeter in thickness, after three weeks of treatment the left eye presented only a slight and altogether superficial opacity, while on the right eye there was simply a very thin pannus. In cases of recent trachoma, both of the granular and papillary forms, the quantity of iodine should be increased to 3 and even 5 per cent. As oil of vaselin does not dissolve more than  $\frac{1}{4}$  per cent., a little sulphuric ether—or, better still, rectified petroleum—should be added in order to obtain a more concentrated solution of iodine. Painting the palpebral conjunctiva with these strong solutions generally causes a good deal of discomfort; the mucous membrane becomes red, the eyes water and the patient suffers acute pain, which is, however, of but short duration. After four or five applications a catarrhal condition ensues, accompanied by copious secretion, congestion and slight tumefaction of the mucous membrane. At this stage, in addition to the application of iodine twice or thrice daily, Neznamoff lightly cauterizes the conjunctiva with a solution of nitrate of silver of the strength of 2 per cent., washing the eye immediately afterwards. In addition to this he lances the largest granulations and expresses their contents. In cases of recent trachoma with abundant secretion at the outset, before employing the strong solutions of iodine it is advisable to apply glycerin mixed with one-half per cent. of iodine in order to arrest the secretion.

The excellent results of Neznamoff's plan have been confirmed by Dr. L. I. Hirschmann, Professor of Ophthalmology in Kharkoff. He has found it useful in cases of granular ophthalmia and also in other ocular diseases. Thus cases of inveterate blepharitis of the ciliary canal will rapidly mend when liquid vaselin containing iodine in the proportion of one-half or one per cent. is applied to the eyelids. Instillations of several drops of this same solution are beneficial in cases of inflammation of the lachrymal sac. Finally, old infiltrations due to parenchymatous keratitis become reabsorbed on a solution of iodine in liquid vaselin of the strength of 2, 3 or 5 per cent. being applied to the palpebral conjunctiva. Solutions of iodine in oil of vaselin, obtained by the addition of sulphuric ether or by essence of petroleum, should be kept in the dark in well-sealed bottles. They remain clear for about a week, after which time they become thick and are no longer fit for therapeutic purposes.—*Therapeutic Gazette*, May 15, 1896.

## MONTHLY RETROSPECT OF HOMEOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D.,  
FRANK H. PRITCHARD, M.D., AND F. MORTIMER LAWRENCE, M.D.

**CANTHARIDES AND ARSENICUM IN ALBUMINURIA.**—According to Dr. Charles W. Hayward, cantharides is in acute cases one of our best remedies. There is acute congestion of the kidneys, scanty urine containing albumen and perhaps blood, constant desire to urinate. In suppression of urine it is of great value. Ringer says: "The preparations of this medicine have been recommended by high authority in certain forms of Bright's disease; but it has for many years been considered a most dangerous remedy in diseases of this kind, and its use is customarily condemned in most books which treat of kidney diseases. The discrepancy concerning their usefulness perhaps arises from the difference in the dose in which it has been administered by different observers. The author is convinced of its usefulness in acute Bright's disease when the acute inflammation and fever have subsided, as they invariably do about the fifth to eighth day. After the subsidence of the more acute disease in the kidney, it not uncommonly happens that a chronic one follows, and in consequence the urine continues small in quantity and contains albumen and blood. If, just at this time—that is, on the immediate subsidence of the acute inflammation—tincture of *cantbarides* be given in one-minim doses, to be repeated every three hours, the blood will almost always very quickly disappear, while the albumen more gradually decreases and the urine becomes more abundant." *Cantharis* in still smaller doses will be of great service at an even earlier stage than mentioned by Ringer. It is about our best medicine for really acute nephritis.

Arsenicum is a drug which most closely corresponds with Bright's disease after the acute inflammatory stage is over and when the *cantbaris* condition is passed. It has a distinct influence on the kidneys. They are irritated, and in chronic poisoning we find that the kidneys are enlarged and hyperæmic, the epithelial cells charged with fat and granules. The kidneys are identical in their condition with the "large white kidney." Urine is scanty, albuminous, urea diminished. Dropsy occurs and anasarca. The appearance of the patient is pasty, and he suffers from the debility, languor and digestive troubles found in Bright's disease. We could not wish for a closer correspondence than is to be found between arsenic and chronic nephritis, and by its careful administration cure may often result when the structure of the kidney has not been too seriously injured for repair. Great improvement, locally and generally, can always be obtained.

Dr. Hayward also recommends *aconite*, *belladonna*, *berberis*, *ferum muriaticum*, *mercurius*, *phosphorus*, *phosphoric acid*, *plumbum* and *terebinth* for appropriate conditions.—*Am. Hom.*, April 1, 1896.

**SENEGA IN HYPERPHORIA.**—This remedy is of first importance in weakness or even paralysis of the recti and oblique muscles, especially in hyperphoria. The patient will usually complain of dull, tired, aching or pressive pains in, around or behind the eyes, with smarting and burning in the eyes, always worse after any use. There may be conjunctival catarrh, and often general headache or dulness in the open air.—*Hom. Eye, Ear and Throat Journal*, April, 1896.

**EQUISETUM HYMALE IN URINARY DISORDERS.**—According to Dr. Dewey, *equisetum* acts similarly to *cantbaris*, but it has less tenesmus and less haematuria and the urine is less scalding. There is pain in the bladder, not relieved by micturition; the constant desire to urinate is not relieved even by copious urination. The urine is scanty, high colored, and contains much mucus. Much mucus in the urine is more indicative of *equisetum* than of *cantbaris*. The general aggrava-

tion of the drug seems to be immediately after urinating. It has proved useful in enuresis with marked vesical irritation, being similar here to *eupatorium purpureum*, which is a useful remedy in the vesical irritation of women, with much burning in the urethra during urination. With the foregoing symptoms, *equisetum* becomes an important remedy in cystitis. It has been suggested in the dysuria of children; the pain being worse after urinating will distinguish it from *petrocelinum*, which has the symptom that the child dances up and down with pain when the urging to urinate comes on.—*Med. Century*, March 1, 1896.

**CAUSTICUM IN URINARY DISORDERS.**—Dr. Dewey says that in paralytic conditions about the bladder *causticum* deserves first place. It is one of our great remedies in enuresis, and its characteristics are involuntary micturition at night in sleep, when coughing, sneezing or blowing the nose, showing a weakness of the sphincter. Another indication of this is the difficulty the patient has in passing the last few drops of urine, the fact that he has to wait a long time before it starts and that during the act it is expelled very slowly, showing not only a weakness of the sphincter, but a weakness of the whole muscular system of the bladder. Nocturnal wetting of the bed in children, occurring during the first sleep at night, calls for *causticum*. Paralysis of the bladder after labor also calls for this remedy. *Zincum* is another excellent remedy in these bladder troubles, and it has some symptoms similar to *causticum*, such as involuntary spouting of urine when coughing or sneezing; there is apt to be more pain in *zincum* cases, however; *squilla* and *natrum muriaticum* also have involuntary micturition when coughing. Another symptom of *causticum* is an excessive deposit of urates in the urine. Another remedy which clinically has proved very useful in enuresis from weakened muscular action is *ferrum phosphoricum*.—*Med. Century*, March 1, 1896.

**APIS MELLIFICA IN URINARY DISORDERS.**—Dr. W. A. Dewey states that the symptom of scanty urine always leads one to consider whether *apis* is or is not the remedy, for although *apis* produces scanty urine, there are a number of other drugs that will do the same thing. The keynotes for *apis* in urinary affections are scanty or suppressed urine, drowsiness, edema in various parts, thirstlessness and suffocation on lying down. The urine is dark, highly albuminous, and contains casts, so it is readily seen how well *apis* may correspond to any form of Bright's disease. In difficult micturition of children *apis* is often a useful remedy. It has frequent desire, with the passage of a few drops at a time. Among other symptoms are great irritation at the neck of the bladder, and incontinence of urine. It is also the remedy to be thought of in retained urine of inflamed bladder after abuse of cantharis.—*Med. Century*, March 1, 1896.

**IODIUM IN CROUPOUS PNEUMONIA.**—Dr. Kiefer is a warm advocate of iodine in croupous pneumonia as was recommended first by Kafka. He claims when indicated that it will have an abortive effect. After four to six doses the dyspnoea will ameliorate, the sense of pressure throughout the chest and the painfulness will decrease, the cough will become looser, the fever decrease within six to ten hours the pulse will sink from 120-112 to 100-92, a mild perspiration will set in, which will be followed by a sense of well-being. If one examines the patient one will find all the objective signs of a pneumonia, but the morbid process has ceased to progress and retrogresses with easy expectoration of mucus which is rarely purulent, but which soon diminishes, so that in twenty-four hours the cough and expectoration may wholly disappear. The provings present burning, tearing or piercing pains, a sensation on breathing as if a great resistance had to be overcome to dilate the chest; cough with dyspnoea, pleuritic pains in the thorax and blood-streaked sputa. Dyspnoea with painfulness on deep breathing, great dyspnoea, lack of breath, etc.

The after-effects of the disease are much rarer under this remedy.—*Homopathische Monatsblätter*, No. 1, 1893.

**EXTERNAL APPLICATION OF HOMOEOPATHIC REMEDIES.**—Dr. Gaudy thinks that we in our reaction against allopathic external measures have overlooked many serviceable points in the use of our remedies externally. *Arnica*, *calendula*, *cominum*, etc., in domestic use yield good results when used externally. The remedy thus acts fully as well according to the law of similars and its action is not diffused through the system to become local later.

*Rhus toxicodendron 3x*, in an alcoholic solution externally, he has found an excellent remedy when locally applied, in indicated cases. It exerts an immedi-

ate sedative action where the same drug used internally failed or was much slower. In cases of adenitis threatening suppuration where hepar sulphuris had been given in vain, the local application of a salve made with the third dec. trit., 1:10, dissipated the glandular enlargement in three days. In other cases mercurial ointment made with the third dec. trit., had a much more rapid effect than the same drug internally, or even than the allopathic mercurial salve.

The third dec. attenuation of phytolacca is more efficacious as a gargle in diphtheritic exudates than the drug internally.

The attenuations of gelsemium applied locally act instantly in indicated cases where the remedy internally is inactive. In ophthalmic affections he claims the results with collyria of solutions of gelsemium are remarkable. Euphrasia applied on compresses or as a collyrium is an admirable measure. Cepa, inhaled, he has observed to cure a case of coryza in a woman with headache, continuous sneezing which kept her awake at night.

Sulphur and phosphorus, respectively, he has applied locally to the chest where they were indicated but did not respond to their indications. A salve of quinine applied to the vertebral column in children, he has seen to cure intermittent fever.

Intercostal neuralgia he has frequently cured with lotions of aconite or spigelia. — *Journal Belge d'Homeopathie*, Dec.—Nov., Dec., 1891.

**ZINCUM IN DIPHTHERIA.**—Dr. Woodward says, "in cases of diphtheria where there no longer seems any hope, I have found zinc to act as by enchantment. It is indicated when the disease begins in the pharynx and descends into the larynx, with great infiltration of the glands, great pallor, very weak and irregular pulse, feet and hands cold. It is especially indicated where delirium or coma supervenes with great prostration." — *Kiri-ta Omnipatia*, Anno, xli., No. 2, 1895.

**MAGNESIA MURIATICA IN LIVER DISEASES.**—Dr. A. Clifton regards the muriate of magnesia as a very important remedy in enlargement and congestion of the liver. The associated symptoms were a bilious diarrhea, headache, pains in the right side, a broad, flabby and yellowish coated tongue, edema of the lower extremities, dyspnea and palpitation of the heart. In four cases out of seven with enlarged and indurated livers which had persisted for months or even years, with frequent attacks of indigestion with disturbances of the secretion of bile, inability to lie on the right side, constipation, etc., preceding, this drug was curative. — *Homeopathic Monatblaetter*, No. 12, 1895.

**INDICATIONS FOR PULSATILLA AND KALI B CHROMICUM IN GONORRHEAL RHEUMATISM.**—Pulsatilla is indicated in gonorrhœal rheumatism where there is aggravation from heat and amelioration from cold or pressure; the patient must walk about, but there is no relief from this. The pains are erratic. Kali bichromicum is characterized by wandering rheumatic pains; the pains are localized in small, circumscribed spots, possibly of the size of a ten-cent piece. Warmth always relieves. — *Rivista Omnipatica*—*Ibid.*

**REMEDIES FOR BARLOW's DISEASE.**—Dr. Mossa in an abstract from an allopathic journal on this affection, suggests the use of merc., mezer., phos. acid, phos., asa, sabina, guaiac. staphys., sulph., calcar., silica. The proper selection of foods is also highly important. — *Allgemeine Homeopathische Zeitung*, Nos. 22 and 23, 1895.

**KALI IODATUM IN ASTHMA.**—Dr. Dewée was consulted by a man of 32 years, of a very robust constitution and with no previous history of syphilis, on account of crops of boils and periodic asthma, which latter appeared three or four times a week. After employment of a number of remedies without success, he received kali iodat., 1x. In two to six months he was freed from his boils and asthma respectively. Up to his tenth year he had suffered from crusta lactea, which had been dried up by oil of cade.

The action of the iodide of potash upon the lungs has been known for some time. Fournier, *Traité de Syphilis*, p. 403 and 415, describes the picture as follows: "You have prescribed your patient the iodide of potash, and possibly the following night or the next morning you are called in all haste to find your patient in a terrifying state. He is lying down anxious, excited and the prey of an actual anguish; he complains of violent headache breathes with difficulty and his face is distorted, swollen and red. Inspiration is especially difficult, long and noisy—there is actual dyspnea and then orthopnoea."

Jousset, of Paris, describes as characteristic of the drug: "dyspnœa, difficult and gasping breathing, a sensation of choking, with long lasting asthmatic attacks, with congestion of the chest." Allen in his *Encyclopædia* presents symptoms of bronchitis, dyspnoea, with loss of voice from œdema of the larynx.—*Die gesamte Homœopathische Zeitung*, Nos. 21 and 22, 1896.

**HEILONIAS IN DISEASES OF THE FEMALE GENITAL ORGANS.**—Dr. Kopp states this drug first to have a congestive action upon the sexual organs of women, while secondarily an atonic condition results; hence, in the former states the higher dilutions should be indicated and the lower in atonic affections. Prolapse of the uterus from lack of elasticity of the uterine ligaments is one indication. Prolapse with ulceration of the cervix and discharge of dark and stinking blood are symptoms calling for it. Pruritus of the vagina and vulva finds in it a serviceable remedy. This pruritus is a frequent accompaniment of cervical ulceration with a white and disagreeable-smelling leucorrhœa and discharge of blood upon slight exertion. In such cases he not only administers the drug internally, but advises vaginal irrigation with a solution of thirty drops of the tincture of helonias to a pint of water. Again, where the menses are suppressed and there are symptoms of congestion of the kidneys with albuminuria, it will be found indicated. Also during the climaxis where there is a feeling of weakness and pressure in the region of the sacrum, possibly joined with prolapse of the uterus and associated with a sensation of great weakness and melancholy. Profuse hemorrhages during this period of life, accompanied by profuse leucorrhœa and violent pains in the uterus and ovaries also point to helonias as a remedy. A threatening miscarriage dependent upon atony may be prevented by the use of this drug, he asserts. A fatiguing pain in the small of the back, running into the limbs, is characteristic of our drug. In cases of sterility with weakened sexual powers and desires he advises its trial.—*Homœopathische Monatsblätter*.

**SULPHUR IN CHRONIC ECZEMA.**—Dr. Oscar Hansen, of Copenhagen, Denmark, reports the case of a well-to-do patient of fifty-seven years, who for two years had been troubled with an eruption on the back of his neck and the uppermost portion of his back. It consisted of closely-lying papules which itched very much and desquamated. The itching was worst during the night from one to four, and after scratching the eruption burned severely. Otherwise he felt well. Arsen. 2c. and 3x., three drops three times a day and a local application of lanolin, 2pts., vaselin and water in one pt., were prescribed. He noticed a decided improvement. But a lack of progress led to the prescription of sulphur 2c., five drops three times a day and the local application of a salve consisting of flowers of sulphur, one part, and lard, fifteen parts. In a month and ten days he reported himself well.

A second and similar case was that of a seamstress of thirty-one years, who for about six months had suffered from a multitude of red papules and a few scattered pustules upon her chin and cheeks. They did not itch but had tearing pains run through them upon becoming warm in bed. On her chin the papules were upon a background of normal skin, while upon her cheeks the surrounding skin was red, infiltrated and inflamed. Otherwise she was well; no aggravation during menstruation. Tinct. sulphur, five drops three times a day was ordered and each evening a dusting powder of one part of sublimed sulphur to two of rice powder was also advised. Only boiled water was allowed in washing her face. Under this treatment the sensation of heat, stitching pains and papules decreased, the inflamed skin of her cheeks became nearly normal except a slightly noticeable desquamation with great dryness and burning in the cheeks, for which she received ars. alb. 3x., three drops three times a day. Not long after she was entirely well.—*Maaenedskrif't over Homœopathi*, No. 2, 1893.

**THE GRAPHITES PATIENT**—The patient calling for graphites is an enlarged pulsatilla subject, with a well-developed emotional sphere, large bones and high forehead, slower in movement but also of a mild disposition as with pulsatilla. She is inclined to become obese and to suffer from constipation as well as from skin diseases, especially from cracks and fissures of the skin. Pulsatilla has aggravation from milk, while graphites presents amelioration from warm milk. This is an important and practical distinction. Periodicity every seven days—canth., croc., gels., nux mosch., phos., phyt. sanj. sep., sil. and sulphur.—*Rivista Omnipatica*, No. 5, 1893.

**PILOCARPINE IN SALIVATION.**—Dr. Berlin, after mentioning the fact that among the drugs which cause salivation mercurius, pilocarpin, physostigmin, nicotin, digitalis and iodum stand first and foremost, relates the case of an elderly and corpulent woman who consulted him on account of an attack of salivation which had troubled her for about three weeks, and for which he could find no apparent cause. After treating her with bell. 3x for some time no improvement. Pilocarpine 6x was then administered, with good results.—*Leipziger Populäre Zeitschrift Fuer Homeopathie*, Jhrg. 26, Nos. 23 and 24.

**TEREBINTHINA IN NEPHRITIS AFTER SCARLET FEVER.**—Dr. Pfander records the case of a boy of four years who, March 10, 1891, was seized with the apparent signs of a catarrhal pneumonia seated in the posterior and lower portion of the right lung, which yielded to iod. 3x in a few days. March 24th he desquamated, which revealed the case to be larvated scarlet fever. His sister had some time before been sick with this disease. At the same time there was slight œdema of his face, for which apis 5x was given. The urine contained albumin and casts, and as no change for the better followed, March 27th phos. 5x was prescribed. March 30th, his urine contained quite a little blood, phos. 5x and ars. 3x. April 3d, a little less albumin and a trace of blood. As by April 10th there was no change, canth. 3x was ordered—no results. April 1. th, tereb. 3x, five drops every two hours, and the quantity of blood in the urine decreased at once, while the albumin remained but little affected; but at the beginning of May there was still a slight turbidity in the urine on boiling. This yielded to acid. nitric. 3x. As the blood so rapidly yielded to tereb. after resisting various remedies, he gave the credit to this drug.

The writer also reports a number of other cases where the urine became albuminous and bloody from complicating nephritis, with other primary diseases, as diphtheria, rheumatism, or, better said, peliosis rheumatica, and in another case of scarlet fever, where terebinthina removed the blood from the urine, though albumin remained. Nitric acid he has found to influence the latter symptom better than other drugs.—*Allgemeine Homeopathische Zeitung*, Nos. 3 and 4, 1891.

**THE ACTION OF TEREINTHINA ON THE KIDNEYS.**—Dr. Pfander, in a paper read before the last meeting of the Swiss Homeopaths on terebinthina, after referring to its action on other organs, discussed its influence on the kidneys, its most characteristic centre of action. Here its pathogenic influence is intense, for the provers complain of a sensation of weight in the renal region with burning and drawing pains, sensitiveness to pressure over the kidneys, tenesmus and cutting pain in the bladder, burning pain or urination, etc., all symptoms pointing to great irritation of these organs. At first the urine is decreased in quantity, but gradually passing on to complete suppression. As long as it is increased in quantity it is light-colored, but as it decreases it grows darker in color, finally to contain blood, even to be nearly pure blood. At the same time it frequently contains a mucous and reddish-white sediment which consists of blood and renal detritus. Therefore it is indicated in renal haemorrhages with irritative symptoms as well as in acute nephritis either with or without admixture of blood in the urine. It is more closely indicated where there is considerable desquamation and red blood-corpuscles in the urine, which give it a reddish-black or a so-called smoky appearance, with a blackish sediment forming in the vessel. This condition is most often observed after scarlet fever or diphtheria, and the albuminuria accompanying is usually considerable. Here he has found it frequently of service. The disease is then in its acute or subacute stage. He never has found it useful in the chronic form.

Also in acute cystitis with haematuria terebinthina may be valuable, yet cantharis will generally help one better out. Hering recommends it in gonorrhœa with strangury and tenesmus of the bladder, soreness of the uretha, as well as in puerperal nephritis with a burning and a pressing down sensation of the uterus. The drug does not present any decided symptoms in the provings on the sexual organs. It is very striking how near our drug resembles cantharis in its action on the kidneys. Phosphorus is its antidote.—*Allgemeine Homeopathische Zeitung*, Nos. 3 and 4, 1891.

[Kobert (*Lehrbuch der Intoxikationen*, Stuttgart, 1893; p. 391) says that turpentine produces a catarrh of the tubuli recti—a renal catarrh. Burt (*Pathological Materia Medica*, Chicago, 1833) claims that the drug is especially indicated in the subacute and chronic forms of nephritis; if there is no blood in the urine terebinthina will fail.—E.Ds.]

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## THE PRESENT STATUS OF ANTISEPSIS IN THE HOMOEOPATHIC SCHOOL.

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(Read before the American Institute of Homœopathy, Session of 1896.)

WE are living in an age of medical fads and medical innovations. Hardly a week passes that some new theory of disease, some new surgical operation, some new method of diagnosis or some new "cure all" is not announced. The medical profession as a whole, while constantly calling attention to the abnormal credulity of the laity, is itself credulous to an extreme degree. Fads have come and fads have gone, and doubtless fads innumerable will dot the medical horizon for countless ages to come.

While the older school has been, and is, ever seeking for therapeutic methods which are universally applicable to given diseases, homœopathy has kept on in the even tenor of her way, so far at least as internal medication is concerned, and still believes that she has the best and most universally applicable law of cure yet enunciated. However, as a school we have witnessed during the last decade the rise and fall of so

many vaunted "specifics" that we are in danger of having our normal receptivity transformed into abnormal incredulity.

Truth, wherever found or by whomsoever disclosed, is the exclusive property of no man or no set of men; and, for humanity's sake, be it said, the code of all schools of medicine justly brands him who would for personal aggrandizement conceal any therapeutic procedure of benefit to humanity as a charlatan and an impostor. I have but little use for the man who will cast aside well-tried and oft-proved methods and chase every therapeutic *ignis fatuus* which comes within his range of vision; and I have still less use for him whose faith is so fixed in some therapeutic dogma that he can see nothing which is without the pale of that dogma. Either is a dangerous man to tie to, and the time is rapidly approaching when an intelligent public will so judge him.

I have indulged in the foregoing prelude for the purpose of giving what seems to me the explanation of the opposition which exists in certain quarters, largely in the homœopathic school, to the doctrines of antisepsis. There are men who seem to fear that the law of similars will go to the wall if the germ theory of disease, upon which antisepsis is based, is fully established. These gentlemen do not seem to realize that the whole genius of antisepsis consists in the *prevention* rather than the *cure* of disease. But antisepsis, no matter to what department of medicine it is relegated, has outlived its experimental stage. It has come to stay and is to be with us for all time.

Asepsis is but the fruit of antisepsis. There is not an advocate of antisepsis living who would resort to chemical germicides if he thought that perfect asepsis could be obtained without their use. That this is not possible is the consensus of opinion of at least 99 per cent. of the practical surgeons of the world.

I cannot in this paper discuss the so-called germ theory of disease. My chief object is briefly to consider and to rebut the arguments which the opponents of antisepsis put forth. These may be stated as follows:

1. That certain prominent surgeons still ignore antisepsis *in toto* with results equal to those obtained by the most rigid disciples of antisepsis;

2. That certain dangers attend the use of chemical germi-

cides, which more than offset any good which may come from their use; and

3. That it is possible by internal medication and hygienic treatment to so favorably impress the system as to make the multiplication of organisms within the body harmless or impossible.

"That certain prominent surgeons still ignore antisepsis *in toto* with results equal to those obtained by the most rigid disciples of antisepsis."

Lawson Tait is the one man above all others who is quoted as the chief anti-antisepsis apostle. He is referred to by big men and small who still contend that the germ-destroying agents are unnecessary. Very few of the men who so persistently quote Tait in this connection have seen him work. On the other hand, I cannot at this moment recall one surgeon of prominence in this country who has seen him operate who is not a firm believer in antisepsis. That Tait is a remarkable surgeon his worst enemies will admit; and it is his wonderful dexterity which has, in my opinion, enabled him to accomplish the results which he has accomplished in the old-time way. However, while this surgeon may be more than ordinarily successful in the saving of life, he is not an ideal surgeon. One has but to go from his clinic to the clinics of such men as Martin, of Berlin, or Leopold, of Dresden, to become a firm believer in antisepsis. The English surgeon is slovenly, his wounds are frequently infected and he uses drainage often. The Germans are clean, pus in the healing of wounds is almost unknown to them, and they rarely resort to drainage. The contrast is most striking and the conclusions inevitable. Bantock, who is also frequently quoted as opposed to antisepsis, is a thoroughly clean operator and may well be dubbed the apostle of asepsis. That Bantock's results are good no one will deny; that they might be better were he to practice antisepsis is not improbable. At any rate one is impressed with his extreme cleanliness. Now, why this extreme cleanliness? The question is certainly a pertinent one and cannot well be answered without admitting the probable correctness of the germ theory of disease. If, then, more perfect asepsis can be obtained by germ-destroying agents, and if the use of such agents is unattended by danger, is it not better to be on the safe side and use them?

Tait is at least consistent and permits the germs to fight their own battle after entering the system. Bantock is clean because he desires to prevent germs and infected matter from entering the system. I believe, from personal observation and from what others have told me, that both of these gentlemen have to contend with pus much oftener than do modern antisepticians.

"That certain dangers attend the use of chemical germicides which more than offset any good which may come from their use."

I do not deny that harm has been done in the past by the so-called chemical germicides. In the early days of Listerism the stronger solutions of carbolic acid and bichloride of mercury were used, and many cases of poisoning were reported. Then, too, the chemical antiseptics were introduced into parts of the body where we would not think of introducing them at the present time. The peritoneal cavity was irrigated with the carbolic and mercuric solutions; the same solutions were applied directly to the meninges of the brain; the uterine cavity was doused with mercuric solutions as strong as one to one thousand, and, when used in any of the natural or artificial cavities of the body, suitable drainage was not provided for. It was not strange, under the circumstances, that mercuric and carbolic poisonings were common. It was difficult for Lister and his early followers to comprehend, at a time when bacteriology was in its infancy, that mercuric solutions of the strength of one to five or ten thousand could possess germicidal properties.

Time has taught us many things regarding antisepsis. All antisepticians admit that heat in some form is the best of all germ-destroying agents. Unfortunately it cannot be applied to living tissues when primary union is the object sought for, and I believe that the application of the actual cautery to pedicles highly endowed with nervous tissue, and to the lower orifices of the body, is to be deprecated. It can, however, be utilized in the sterilization of instruments, dressings, ligatures and water, so that the stronger solutions of the chemical agents can be reserved for the hands and skin surfaces, while the weaker ones only are to be used in open and extensive wounds. These are the general principles of antisepsis as practiced by the rank

and file of the practical surgeons of the day. By observing these principles no serious harm will follow in the train of the germ-destroying agents.

Occasionally cases will be met with of peculiar idiosyncrasy which will manifest toxic symptoms, even though every precaution is observed. Fortunately we are now sufficiently familiar with toxic symptoms of the germicides in general use to enable us to recognize them at their very onset and to withdraw the active agent before the system is profoundly impressed. Compared, then, with the statistics soon to be presented, the danger attending the intelligent use of antiseptics deserves little more than passing notice.

"That it is possible by internal medication and hygienic treatment to so favorably impress the system as to make the multiplication of organisms within the body harmless or impossible."

No one will, I think, dispute the advisability of getting the system into as perfect working order as possible previously to the operation. This goes without saying. Unfortunately, however, the surgeon many times has to work under the most adverse circumstances for all parties concerned—except the germs. Perfectly well people rarely submit to the surgeon's knife. The system is often surcharged with pus, or the tissues are so affected by long-continued disease that they offer but feeble resistance to the entrance and multiplication of living organisms. Undoubtedly proper hygienic and internal treatment, combined with certain sustaining and eliminative measures which are now well known, is of the greatest utility. So, too, are certain remedial agents efficacious in the treatment of scarlatina, but, because this is so, no sane physician would be so foolish as to expose his child to scarlatina if he could prevent such exposure! I do not believe that I am carrying the philosophy of analogy too far in making this comparison. I am assuming, of course, that both surgical fever and scarlatina are due to specific germs—a theory which has more of the evidences of truth on its positive than on its negative side.

Unquestionably the diminished mortality in surgical work can be attributed in a measure to improved technique, but this can hardly be said of certain operations, notably amputations. Let the reader compare the old *régime* in amputations, with its

from four to eight weeks of suppuration, with the present method of ten days' undisturbed dressings and pusless union. The technique of amputations—so far as mechanics are concerned—is practically what it was twenty years ago, and the more favorable results can only be accounted for by the application of antisepsis. Such at least seems to me the logical conclusion to which any unbiased investigator will come if he start from proper premises. It matters but little to the practical surgeon whether streptococci and other forms of bacteria are the *cause* or the *result* of pus. Sufficient for him is the fact that *they are found with pus, and that by resorting to certain precautions implied by the term antisepsis both germs and pus can be excluded in the healing of wounds.*

Finally, the ultimate test of all systems and methods of cure, or prophylaxis, must be the results obtained. What has been said of amputations applies with equal force to nearly all operations. Antisepsis has wrought a revolution in surgery. It has reduced the mortality in celiotomies from 75 to less than 5 per cent. It has, according to the latest statistics, diminished the mortality in breast amputations from 20 to 1 per cent., notwithstanding the fact that the modern technique in this operation is infinitely more complicated and destructive than it was in the older operation. It has begot a degree of confidence on the part of the surgeon which has led him to explore, and with comparative impunity, almost every organ and part of the body, the brain not excepted; such explorations having resulted in numberless operations and cures, which a few years ago were not dreamed of even by the most sanguine. It has robbed the lying-in room of much of its former terror, and it has reduced the death-rate from so-called puerperal fever in certain lying-in hospitals from 40 to one-half of 1 per cent.

The foregoing data can be verified by any one caring to take the time to investigate the subject himself. The evidence going to prove the value of antisepsis would seem to be overwhelmingly convincing to even a casual investigator. However, the fact cannot be ignored that a very large per cent. of the general practitioners of the country are sceptical regarding the claims set forth. This scepticism is based on personal experience. Many of these gentlemen follow, after a fashion, the rules of antisepticians, but they have to contend with suppara-

tion nearly, if not quite, as often as before the age of antisepsis. Their failure can be accounted for in two ways:

1. As general practitioners, they are constantly coming in contact with contagious, infectious and septic diseases, which make perfect disinfection of the clothing and body exceedingly difficult, and oftentimes impossible.

2. Many of them do not fully comprehend the philosophy of antisepsis and, consequently, carry out its principles but imperfectly.

1. Very few general practitioners, especially in rural regions, can get on without doing more or less surgery, and it is right that they should do it. However, for the reason given, I contend that capital operations, other than acute cases, and especially those involving the peritoneal cavity, should be assigned to the exclusive specialist. Medicine is now too comprehensive a science to be covered by any one man. Indeed, it requires more than the ordinary mind to keep apace with the literature of any one of its several departments. The general practice of medicine constitutes in itself one of the most important of the specialties, and affords innumerable instances for the intelligent application of the principles of antisepsis. Much which has been accomplished in the field of preventive medicine has been done through the means of antiseptics, and the physician who to-day ignores antisepsis and antiseptic agents in the treatment of disease, either medical or surgical, is in my opinion depriving his patient of one of the most valuable of modern discoveries.

2. The successful antiseptician must constantly bear in mind that, like a machine, antisepsis is no stronger than its weakest part. In a given operation, the operator may rigidly carry out all antiseptic details with one single exception, which exception may contaminate his wound and spoil the operation. It requires an endless amount of work to apply successfully the principles of antisepsis. No one can master these principles without a working knowledge of bacteriology. He must know, first of all, the relative power of the several germ-destroying agents and their effect when applied to the living tissues. He must know the probable sources of wound infection, and he must know how best to make the field of the wound aseptic previously to the operation and how best to keep it free from

harmful organisms during the operation and during the healing process.

Time forbids an extended discussion of the details suggested by the several requirements given. I shall but briefly consider a few general principles:

(a) The agents employed should be those which bacteriological research has shown to be germicidal. Only the weakest possible solutions known to possess germicidal properties should be used in open wounds. Under no circumstances should the stronger solutions of mercury or carbolic acid be left in natural or artificial cavities of the body.

(b) The operator and assistants should guard their persons in every way from infection. The abdominal surgeon should never come in contact with contagious or infectious diseases of any kind. Frequent bathing of the entire body is necessary. In the event of contact with any of the contagious or infectious diseases corrosive sublimate (1 : 2000) should be used to cleanse the person. No clothing should be worn in the operating room which has been exposed to infection. During the operation, sterilized gowns should cover the clothing. The head should be covered with sterilized gauze. The hands of the operator and assistants should be prepared, after the method of Kelly, by washing them respectively in saturated solutions of permanganate of potash, oxalic acid and soda, and then for five minutes in a 1 : 1000 mercuric solution.

(c) The patient should be prepared, when possible, by having a bath the night before the operation; the alimentary canal should be emptied, and the lower bowel washed with an enema not later than two hours preceding the operation. The field of the operation should be thoroughly scrubbed with a 1 : 1000 bichloride solution at the time the bath is given, the parts shaved and a 1 : 2000 bichloride compress placed over them. In operations within the genital tract or the abdomen a 1 : 2000 vaginal douche should be given, and the vagina packed with iodoform gauze.

(d) In operative work outside of hospitals, a room should be selected possessing a good light—preferably with a southern exposure. Inquiry should be made as to whether the room has been recently occupied by contagious or infectious diseases. If an abdominal section is to be made, old paper should be re-

moved, the walls and floor washed with a 50:1000 carbolic solution, and followed by sulphur disinfection. All mattings, curtains, tapestry and unnecessary furniture should be removed.

(e) Heat is the best of all agents for sterilizing instruments, towels, dressings and water. Water should be boiled for one hour in a clean vessel, strained and cooled. Instruments are sterilized by boiling for ten minutes in a 1 per cent. solution of carbonate of soda. Dressings may be sterilized by either dry or moist heat.

(f) Silver wire, silk and silk-worm gut may be sterilized by boiling. Silk should first be boiled for one hour in a 10 per cent. carbolic solution and then sterilized with the instruments previously to each operation. The only absolute method of sterilizing catgut without injuring it, is by boiling it in cumol according to the method of Kelly.\*

(g) Sterilized gauze and cotton sponges should largely supplant sea sponges, because they are readily sterilized by heat. Sea sponges when used should be prepared according to the method of J. Greig Smith,† and should be used but once.

(h) The field of the operation should be thoroughly scrubbed in a 1:1000 bichloride solution immediately preceding the

\* 1. *Preparation of Catgut.*—Cut the catgut into desired lengths, and roll twelve strands into a figure of eight, formed so that it may be slipped into a large test-tube.

2. Bring the catgut gradually up to a temperature of 80° C., and hold at that point for an hour.

3. Place the catgut in cumol, which must not be above a temperature of 100° C., raise it to 135° C., and hold it at that point for an hour.

4. Pour off the cumol, and either allow the heat of the sand-bath to dry the catgut, or transfer it to a hot-air oven, at a temperature of a 100° C., for two hours.

5. Transfer the rings with sterile forceps to test tubes previously sterilized as in the laboratory.—*Johns Hopkins Hospital Bulletin*, February, March, 1896.

Messrs. Johnson and Johnson have prepared for me a "ten-day" chromicised catgut, which is most satisfactory and which I am using in all my plastic work.

† *Preparation of Sponges.*—The sponges are frequently washed in water for the purpose of removing all sand and dirt. This requires several days. They are next soaked for three or four minutes in a 1 per cent. solution of permanganate of potash. The permanganate is then washed out by repeated squeezings in fresh water. Next they are placed in solution of sodium hyposulphite, of the strength of half a pound of the salt to a gallon of sterilized water, to which an ounce of oxalic acid has been added. Finally, they are washed in cold sterilized water, dipped in a 5 per cent. carbolic solution and dried. They should be kept in a perfectly tight glass jar until used, when they are to be again washed in a 1:1000 bichloride solution and then in sterilized water.

operation, and the parts shaved the second time. Wounds outside of the peritoneal and cranial cavities should be constantly irrigated or sponged during the operation with a 1:5000 bichloride solution. The wound should be dressed with iodoform, iodoform and bichloride gauze, and sterilized cotton, which are to be kept *in situ* by means of straps, collodion, or a sterilized bandage.

(i) In the after-treatment of all surgical cases, everything coming in contact with the wound should be *thoroughly sterilized*. Post-operative infection is most common. The extreme precautions taken during the operation will avail the surgeon but little if his nurse or assistant is careless in the subsequent handling of the wound. As a rule, the dressings do not have to be removed for ten days, when, if no infection has occurred, union will be complete.

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### SOME SIMILIA SIMILES.

BY L. C. McELWEE, M.D., ST. LOUIS.

(Read before the American Institute of Homœopathy, June 22, 1896.)

*Mr. President, Ladies and Gentlemen:*

THE title of this paper is sufficiently comprehensive to admit of similes on every point of homœopathic philosophy, but we are sure that you will be pleased to learn that it is not our intention to reach the ultimate possibilities of the caption, but merely to touch the subject in high places, as it were.

We have often seen a lad "skip" a flat stone on the surface of smooth water, which left expanding circlets behind it, finally merging into an undulating path, which in turn extended its wavelets to the adjacent fluid until the whole surface vibrated with a wavy tremulous motion.

If the ideas contained in this paper, shied at the broad expanse of its subject and projected on the ocean of thought here present, create a shimmering line of thought, coruscating with "similar" notions, the purpose of this paper will have been accomplished and we shall be happy.

The teachings in Hahnemann's *Organon* are so radically dif-

ferent from the traditions and practices that we have accepted for so ! these many years, that when coming across them for the first time one naturally shrinks from their immediate acceptance, because they are not at once self-evident. On the contrary, the Law of *Similia* is to all appearances a flat contradiction, but the experience of a hundred years has demonstrated that it is no such thing, and, therefore, if it has the appearance of being a contradiction and is a real truth, it is necessarily a paradox. And so it is, of the most pronounced type. Since paradoxes are merely truths in disguise, it becomes the duty of the advocate of their principles to demonstrate them and to remove the masks which hide their beauties from the uninitiated.

Being forced to admit that we have a paradox to put into practical application, we naturally seek to examine its most salient points, and in so doing at once come across these three, which we will consider, *i.e.*, "Drug Action, Primary and Secondary," "Like Cures Like," and "Potentiation."

In the "wild and woolly West," or in that part of creation so considered by the more ancient East, homœopathy is yet in comparative infancy—at about that period of existence which would correspond to the teething period of a growing babe. Being yet in swaddling garments, and having to be vouched for, it is often necessary to leave the high standard of finished and technical language in which the more highly educated would find pleasure and receive understanding, for the simpler and plainer speech of the realm—to put the pabulum of homœopathic truth in such homely form that the minds of the inhabitants can assimilate it.

To this end it is often necessary to construct figures of speech containing a central idea that corresponds to the fact under discussion, and which is familiar enough to the listener to enable him to appreciate its application and be instructed. Even in teaching medical students the intricacies of the *Organon* we have found that this means of instruction has produced the deepest impression and left the clearest understanding of the subject matter.

Unlike the student of to-day, who attends medical college with a teacher to explain the intricacies of the homœopathic philosophy, we studied it alone, and many and long were the hours of reflection on and ruminating of the various para-

graphs before their meaning became clear and their application apparent. Our school was individual reflection, in secluded silence mostly, but often in the loudest uproar. But, whether in the stillness of a night in the country, in the seclusion of a shady spot on the river's bank practicing the art that keeps the White House bereft of a master much of the time, or amid the clamor of a ball game, our teachers were the events constantly transpiring around us, that without language of words became explanatory expressions of problems that awaited solution.

Whether the conclusions arrived at were correct or not, we will leave for the decision of this body, as some of them are here given in the particular form in which they were born, and clothed in the thought raiment which at that time invested them. But whatever that decision may be, they dispelled much of the mist of uncertainty which intervened between us and a clear understanding.

#### DRUG ACTION—PRIMARY AND SECONDARY.

The whole superstructure of medicine must necessarily rest upon drug action, in its widest sense of application, and it must be conceded that the giving of medicine, to become a science, must be done according to fixed principles. The belief that medicine will finally become an exact science must needs include the proposition that drugs produce certain specific and invariable effects. Then, what is drug action? Hahnemann characterizes it in classic language; we roughly say, it is their (drugs) sick-making power. Experiment determines the fact that drugs cure sick people, and they must do so, therefore, by virtue of their sick-making property. The deduction follows, as the day the night, that no drug will make a sick man well that will not make a well man sick. Experience further determines that drugs have two effects—primary and secondary. How, then, can the same drug cure in two different ways? Because it has two different actions, *i.e.*, a primary and a secondary effect; and the old school prescribes on the indications of the former—when they prescribe on indications—while the new school prescribes on the indications of the latter. But some will say, while I know what you *say*, I do not understand what you *mean*; I cannot fathom that thought at once; please illustrate. Well, my friend, Hahnemann, in Paragraph

63 of the *Organon*, states that "every drug alters the harmony of the vital force more or less and produces a certain change in the state of health of the body for a longer or shorter space of time. This is called primary effect. Although a product of drug action and vital force, it is probably due chiefly to the action of the drug. Our vital force by means of its energy endeavors to oppose this effect. The resulting conservative reaction is an automatic activity of the vital force, and is called after-effect or counter-effect." If possible, the enquirer after light on this subject, or the student reading this passage, is more mystified than before, because of the complexity as well as the newness of the idea, together with the addition of this new element, the vital force. As it is not necessary, or even expedient, at this point, to give an explanation regarding the vital force, we usually say to them that the human body is subject to the same laws as any other body, and that one learns very early in his scientific career that "wherever in nature there is an action, there is a consequent reaction." For instance, if you hitch your thoroughbred trotter to your road cart, get behind him with a whip and lash him savagely until he gets to the top of his speed, and repeat the castigation as soon as he begins to lag, you will travel a greater distance with him in the same length of time by so doing than by any other means. But if you keep up this treatment it will soon be discovered that he will not respond so readily to the stimulus of the whip, and other and more drastic means have to be adopted, until all the spirit in him has been worked out; you have brought him to a condition corresponding to the secondary effect of drugs. Administered in crude form, they set up an intense action, but it soon runs its race and then comes the day of reckoning—the penalty being an actionless constitution. The sensitiveness to drug action has been killed, like the spirit of the horse, by the drug-whip. And as the muscular power of an organism may be exhausted permanently by over-exertion, so may the vital force be destroyed by the constant repetition of crude medicinal agents.

But, you say, I am not yet clear on this point. There is too much "vital force" in your explanation for my understanding. Can you not make it clearer in some other way? Well, yes, as nearly as can be done by omitting one of the essential elements of the proposition. However, if you will take an ordi-

nary convex lens and get it "in focus," you will see the object under the glass very clearly, more so than without it, while if you move the glass away, the object will gradually disappear, until at length it will reappear, but will be inverted and not so distinct. The object in focus in correct position is the primary action of the glass, and the object in focus appearing to be inverted is the secondary action of the glass. The primary effect of a drug being a given one, the secondary effect is just the opposite. Now, those curing the sick by the aid of the primary effect of medicines, do so, as a rule, according to the law of contraries, while those curing by the secondary effect of drugs, do so, almost invariably, according to the law of similars. "Oh, I see," says the inquirer, "*Similia similibus curantur*, the hair of the dog is good for the bite." Not so fast, my friend, with your translation. It is not the hair of the same dog, but that of a similar dog, if you wish to paraphrase correctly. But how can you possibly say that a drug producing a given effect can cure effects similar to those of the drug? It is the very acme of paradoxes to make such a claim; and it is more than that, it is absurd. Now, my friend, you have seen equally absurd and contradictory things, and I will show you from your own experience that this proposition is as practical as any other apparent contradiction which you have seen demonstrated. This brings us naturally to our second point.

#### LIKE CURES LIKE.

You have seen water made to boil by pouring ice-water over the vessel containing it (in the culinary paradox). You have heard silence ensue after the introduction of a humming "A" tuning-fork into an "A" tube, and heard it resume its song on being withdrawn. You have had the burning which follows a swallow of Bourbon vanish on taking a swallow of seltzer water; both of them are irritants, but the one allays the irritation produced by the other. Now, the present application of this fact is this: Whatever life is, and whatever health is, they are modified by the action of drugs. If life is a mode of harmonious motion, and the specific effect of drugs is a mode of harmonious motion (if health is harmony and disease is discord), then as silence results from the meeting of similar sound waves, so harmony is restored to the discordant organism by the meeting

of its specific actions with similar specific actions of the drug kingdom.

And, on the other hand, do you not know that if you strike an "A" chord on the piano, every other "A" string in the instrument will vibrate in unison with it? This fact still further explains how likes are influenced by likes, the former case corresponding to what we term the primary, and the latter to the secondary effect of the drug. Thus, as the harp-strings, tuned to a certain key, are set singing in unison by similar chords sounded by the musician's hand, so are human life-vibrations influenced by similar chords of action when adapted to them by the skilled physician.

The question is often asked, What is the difference between the old and the new schools? My reply is, the same difference as between the north and south poles. By that I do not intend to say all the difference in the world, but that they are diametrically opposite. The difference might be expressed somewhat in this manner: The old school is a system of medicine based on experiments on sick people and dumb animals, while the new school is based on law established by experiments on well people. Medicine given the old way suppresses disease by a superior physical force, while medicine given according to the law of similars cures the sick by suasion. This latter statement I illustrate in this way: Disease may be considered to be a riot of the cells of the body, and like a riot of men who, up in arms, clamor for a point which they deem to be right, will destroy everything in their way to attain it unless restrained, suppressed or persuaded to desist and be quiet. If you place them under arrest, or in prison, they can do no harm, but liberate them and they again congregate and riot. Place a cordon of soldiers, 5000 strong, around them, and no demonstration of a hostile nature will escape them. Remove the soldiers, and the demonstration at once breaks forth anew. But if, on the other hand, some one companionable to them, and who has ideas similar to their own, comes from without and announces to them that, because of certain concessions on one or both sides, the grievance for which they riot has been adjusted, peace and quiet immediately prevail, and the militia are no longer needed. There is no longer a riot to quell, though the same individuals are present who but a moment ago were in a state of frenzy. You

may imprison with morphia the pain of neuralgia, which is peculiar in that it darts and shoots like lightning, and is temporarily relieved by warmth; but as soon as the morphia's effect dies away, the lightning pains reappear. A dose of potentized Magnesia phosp. will persuade the pain to disappear permanently. The cells are certainly in the same location, and apparently in the same condition that they were but a moment ago, but they no longer evolve pain, for their grievance has been adjusted. The disease has been *cured* by suasion; it was only *suppressed* by superior physical force. Crude drugs almost always suppress by preponderance of physical force. Potencies always cure by suasion.

Tom Moore evidently had a glimpse of homeopathic truth when he wrote:

"No flower of her kindred,  
No rosebud was nigh,  
To reflect back her blushes,  
And give sigh for sigh."

The "last rose of summer" was evidently sad because of her approaching demise, and, from the poet's expression, evidently yearned for sympathy. Now sympathy is a feeling corresponding to that of another with feelings kindred in kind if not in degree. Another element of sympathy, we think, is the voluntary assumption of the trouble of another. This brings to mind the axiom that "a trouble shared is half over." If, then, sympathy will relieve the trouble existing in the mind of another, and as sympathy is necessarily in its very nature trouble, we have again an illustration of "like curing like."

This suggests another thought which we very much desire to present, but hesitate to do so because it is treading somewhat upon "holy ground." We do not wish to lightly quote serious Scriptural expressions, but one occurs to us which is so beautifully appropriate that we cannot refrain from using it in this connection. Since the law of cure is concerned in the saving of precious lives, and as the Subject of the quotation not only saved lives but souls, it may not be deemed inappropriate for us to use it here; and having introduced several similes more or less familiar, some of which may have appealed to one and some to another, doubtless this divine one will appeal to all: "For since by man came death, by man also came

the resurrection of the dead; for as in Adam all die, even so in Christ shall all be made alive." So also: As by drugs may come disease, even so by them shall disease be cured; for as by poison one may die, even so by drugs shall he be made alive.

#### POTENTIATION.

The subject of potentiation, however, was the hardest problem, the chief source of worry to us, and presented the greatest difficulty of acceptable solution that we encountered. It was five years before a verdict of our own was reached, for engaged as we were in a country practice—old school—with baseball as a diversion, ample opportunity was afforded to solve the points of difficulty while waiting for a patient, a tooth to pull or to handle a "hot grounder" and get it to first in time to catch the runner. Many and various were the ideas and theories concerning dosage that came up for consideration, but they would all finally become misfits until one day, when the idea of "potency" lost its element of volume or magnitude, preponderance of force and physical dominion, which prior to that time had been considered by us to be its chief attribute.

The idea came about in this way: The ball club of which I was captain was composed of nine men who averaged 170 pounds, and we were pitted against a team from a neighboring town who were mere feather-weights compared with us. We felt as though we were playing against "kids" or mere boys, and were really ashamed to array ourselves against them, for we naturally felt that we would simply "sponge them out." When the game was finished, however, and the dust had cleared away, we were even more ashamed than when it began. The score was as "jug-handled" as one could well imagine, but the handle was in the other fellows' hands. The umpire even was quite a small man, but my, how efficient! Potency then and there acquired a new meaning to our mind—that of *efficiency* or *capacity*. Efficiency becoming a synonym for potency, the whole subject was clad in new meaning. A new light had broken over the entire field of thought, and the things that had been obscure became plain. Potency, considered as power and without qualification *per se*, contrasted with potency considered as efficiency, is like studying a landscape by moonlight one moment and considering it under the full force of the noon-

day sun the next. There was opposing that small team a tremendous force, if it could have been properly utilized, but the conditions were unfavorable. Force cannot always have its own way unconditionally. On this occasion, for instance, those nine big fellows attempted ever and anon to "knock the cover off'n that ball," but they were not "on to its curves" and it persistently eluded their efforts. The curves which that ball described were not wide, and could only be seen by the practiced eye of the umpire, but they were efficient just the same, and the joke was on us, for we couldn't hit it.

Now the lesson we learned from that experience was, that if we desired to utilize the great force resident in our combined muscles we must adapt it to the exigencies of the conditions, and also that a very little *apparent* force, coupled with great capacity, could produce *overwhelming* results.

The application of it to us was the adaptation of crude and refined drugs to the work to be done by them. Unquestionably there is more innate force *per se*, more magnitude of measured power in the crude drug than in the trituration. But the conditions are often such that not all of the force is necessary, certainly not available. The molecules of some forms of matter are too large, apparently, to pass through the interstices leading into the ultimate cells of the living body under certain conditions, or these same molecules are unable in their crude form to leave their impress upon the system, and the cells riot *ad libitum* because of the absence of the pacifying element. Our food, in order that it may serve to nourish the body, must first be changed from its natural or crude state—digested; then, if properly refined, it is assimilated by the cells and becomes blood, muscles and bone—it has become potentized. Now it occasionally happens that the living cells boycott a certain element of the food, and although they suffer its absence intensely, and show it in a hundred ways, they will persist in refusing it lodgment among them, as the striking miners do the advances of the arbitration committee, preferring rather to suffer than to take the apparently distasteful (crude) material.

For instance, the cells refuse, for some reason, to assimilate lime from the food. The body emaciates, the bones soften and bend, and the dismal picture of rachitis is developed. Undoubtedly lime in the tissues, in the proper proportion, is the

only thing that will restore them to their pristine condition; but while that is true, a barrel of lime, if it were possible to be given at one time, would not accomplish the desideratum, for it has been boycotted. The striking miners really need money to sustain themselves, but they must have it under conditions that suit *them* or they will not take it. The cells really need lime, and there is plenty of it in the food taken, but they will not have it crude. Now refine it, potentize it, make it capable, render it efficient by comminution of its molecules until they are so small that they will be able to pass the threshold of the forbidding cells, and what a change will then be wrought! The boycott will be raised. The food material that the builders rejected will be accepted and "become the head of the corner." Harmony will replace chaos, and life's harmony will be as sweet as before.

The same reasoning obtains in the case of the so-called inert class of drugs—the pure metals. There is surely more intrinsic power in a section of railroad iron than there is in a very small key, so much more that the key might easily represent the tenth attenuation. And yet, with all the immensity of innate strength in that crude piece of iron, it is incapable of opening the tiny lock that the key fits; whereas, the key, although so light that its presence in the hand is scarcely noticeable, when inserted into the body of the lock and gently turned will move the tumblers in unison and the door will swing open; the bar that held it closed has been moved. It had a *capacity* which did not reside in the greater magnitude of the big rail.

Did it ever occur to you that more keys in a descending scale of size and conformity would open a given lock than if they were in an ascending scale? Beginning with the perfect fit, which represents the correct remedy and proper size dose, reduce the size a shade at a time, and it will surprise you to find how many shades of difference downward you will go before the turning of the key will not produce an effect. On the other hand, increase the size a shade and it is a tight fit, but will turn, although the lock itself is in danger of injury. Increase yet another shade and the key won't fit at all, although of the proper material so far as quality is concerned and of exact conformity. The lock, like the sick individual, must have that particular quality of remedy; but in such large quantities cannot be assimilated, consequently cannot work the combination,

and, therefore, is impotent. By adding force still further you may destroy the lock by attempting to open it with too large a key, as you will the patient by forcing too large quantities of crude drugs into him.

Again, health may be considered to be the victory of the reparative life-forces existing in the body over the breaking-down or destroying death-forces. These two forces are so balanced that during health the destroying or breaking-down force is invisible, as is the Bunsen burner standing beside the arc light. As the balance between these two forces is very even, it only requires a little change on either side of the scale to create a disturbance between them. As the life-force is in the ascendancy during the period of adolescence, the tendency to good health during that time is very great. After full maturity decline begins, when the tendency to grow worse is very great, and the balance is more easily disturbed. Now, since these two forces are so nearly equal, it is readily seen that only a little force is necessary to be added to either to make it more powerful than the other. If the matencies morbi perch on the side of the building-up force, the other, or sick side, immediately gains the ascendancy; but at the same time all the reparative forces are hard at work on their side, and in a little while, or with judicious assistance, will regain its former position, and the destructive force must resume its place in the shade. To illustrate: We once saw ten strong, healthy men attempting to place a railroad rail on a wagon. Their combined strength was almost equal to the task, but not quite. A small boy standing by, observing them, saw their distress, and running up applied his strength, and over the rail went. His strength was to the combined power of these ten men what the twelfth potency would be to a similar amount of disease-force; but his strength was the immediate cause of the loading of the rail, as the small dose of medicine is the immediate cause of the restoration of the lost health. With the great help of the vital force—the men—which must never be lost sight of, small amounts cure. The boy had loaded the rail onto the wagon as drugs cure disease. The combined strength of those ten men and the intrinsic weight of the iron were about equal. It only required a little addition of strength *similar* to that of the men to solve the problem.

As said above, relative to the pure metals, gold in its ordinary

state is only good to stir up strife, lessen McKinley's chances to be President and serve as a plank in a political platform. Under certain conditions, however, it is one of the finest of remedies. Although not all the gold in Eldorado could scatter the despondent clouds that obscure the sweet sunlight of reason in the mind of the unfortunate creature who labors under its suicidal spell, yet gold properly prepared, and rendered efficient, will disperse the clouds in that suicide's mind, leaving it bright and clear, as a northwest wind will drive the clouds out of a winter's day.

Iron as it is taken from the ground, or in its usual form of nails, beams and rails, is only good to build bridges, put up houses and make wheels. But in some forms it becomes an invaluable medicine. Not all the iron in Vulcan's mines, however, could tint the blanched lip and cheek with cherry and crimson and cause the languid eye to glow with the red fire of ardent health, but when needed, if properly prepared, a quantity infinitesimal in itself will accomplish that desired end.

And silver in the form as taken from the mines, or made into money, is of no value to the sick in a curative way, for not all the silver that could be coined at the ratio of 16 to 1 could clear the voice of our Richard P. Bland, made hoarse from long speaking in Congress halls on his pet theme; but an infinitely small quantity, when indicated, can take the huskiness out of the throat, so that the tones that issue therefrom will ring and be sustained and clear as the tinkle of the *dollar* that bears our Richard's name.

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PNEUMONIA APPEARING DURING THE COURSE OF DIPHTHERIA IN CHILDREN.—Dr. H. W. Berg, in summing up his experience with pneumonia complicating diphtheria among the patients of the Willard Parker Hospital in New York, states that pneumonia may complicate any period of the disease. It may be a result of the extension of the primary morbid process to the lung, or be due to infection with other germs, notably with the streptococcus. The pulmonary complications may appear under four forms: Pulmonary congestion, bronchopneumonia, lobar pneumonia, or gangrene of the lung. Of all these, bronchopneumonia is the most frequent. This grave complication is announced by two important symptoms: sudden and considerable elevation of the temperature and excessive dyspnoea. The physical signs may be pronounced, or, if the foci be disseminated, but little apparent. The prognosis varies according to the period of the disease, when it sets in, and whether or no the patient has been tracheotomized. Where it is a direct extension of the diphtheritic process to the lung, the outlook is extremely gloomy. Elevation of the foot of the patient's bed to prevent infection of the lower air passages by gravity, is an important precaution.  
—*La Semaine Medicale*, No. 16, 1896.

## THE PRESENT STATUS OF CRANIECTOMY FOR EPILEPSY.

BY DEWITT G. WILCOX, M.D., BUFFALO, N. Y.

(Read before the American Institute of Homeopathy, June, 1896.)

THE humanitarian nature of the physician would of itself stimulate him to the exercise of his best powers to seek a remedy for that most dread and horrifying disease—Epilepsy. From the time of Galen and Hippocrates to the present era the physician, in a blind, groping way, has been endeavoring to find something tangible to lay hold upon, cast out, and thus destroy the evil spirit.

When we know positively what epilepsy is, what the true pathological condition is, we shall be in a better situation to consider the treatment. To any one who has made a careful study of this affection it becomes apparent that it is not only an essential disease in itself, but is also a symptom or a manifestation of a large variety of pathological conditions which directly or indirectly affect certain cortical centres. It is not safe or wise to treat all cases of epilepsy upon one particular line, even though there is a similarity of local manifestations. Each case must be considered by itself, and if we are looking for genuine idiopathic epilepsy we must exclude such factors as are in the least produced by remote causes.

There are the mechanical causes, as we might properly designate them, old fractures, osseous hypertrophies, tumors, old meningeal haemorrhage, etc. These are quite easily overlooked, as there may be such meagre details of early injury as to quite obscure the facts. Next we have to consider toxic conditions, such as autotoxæmia and alcoholism, then come the almost endless reflex causes, genital, nasal, dental, ocular and gastro-intestinal. I was not a little surprised recently when reading one of the standard medical journals to find the statement by no less an authority than Dr. Frederick Peterson, wherein he says: "I do not remember to have seen among several thousand cases a single one of genuine reflex epilepsy, one that could be proved to be such by the best test of all, a cure under proper medication or surgical procedure." If that be

true, and I am coming to believe that there is a very large element of truth in the statement, then all of our attempts to cure this disease by öophorectomies, amputations of the prepuce, hysterectomies, rectal mutilations have been of no avail. Let any sober-minded surgeon, with a genuine desire to get at the truth for the truth's sake, sit down with his case book before him and count up just how many cases of epilepsy he has cured by operating upon remote organs under the supposition that they were the reflex causative factor, cases that have not relapsed in three months or six months or one year or two years, and I am afraid he will in those sober moments, when he is not buoyed up by the exhilarating wine of enthusiasm, admit to himself that they are very, very few. If then it be true that there are but few genuine cases of epilepsy caused by reflex irritations and comparatively small number caused by traumatism, what then is the cause? Dr. Peterson, than whom none has given more thought and research to the causative *etiology* of epilepsy, says: "Nevertheless, after the most searching investigations, we shall find in the vast majority of cases of epilepsy no cause whatever."

I now come to the real subject of my paper. Does craniectomy give any permanent relief?

The answer to this question must be based entirely upon clinical evidence, theory plays no part in it whatsoever. The fact must be borne in mind, as upon this will depend our prognosis in every case. The older the disease and the more frequent the attacks, the more firmly will be the establishment of the epileptic habit, and consequently the less liability of a cure. It must also be borne in mind that even though the exact cause be ascertained in a given case, and that cause be absolutely and permanently removed, we may yet fail utterly to cure our patient, simply because the epileptic habit may have become so strong and deep that no treatment or procedure can restore such changes. It is therefore self-evident, as has been proven by clinical records as well, that those cases wherein the epileptic habit has been caused by *recent* injuries, and such injuries have produced a direct mechanical pressure, the greater will be the chance of permanent cure. In such cases it has been estimated by carefully selected records, that if 100 such cases were operated upon by trephining and ablation of the morbid

tissues, about 75 per cent. of them would be cured. But unfortunately, as just stated in the opening of the paper, this class of cases comprises but a very small per cent. (1 per cent. it is estimated) of the number of epileptics, and cannot therefore be taken as an index of the curative value of craniectomy. In another class of injuries not recent, and yet wherein the establishment of the epileptic habit dated from such injury, we may expect a cure in about 4 out of every 100 cases.

There is a much larger per cent. of cases of epilepsy caused by old meningeal haemorrhage, congenital or acquired in infancy, giving rise, in addition, to epilepsy, degrees of paralysis, idiocy or other cerebral symptoms, and presenting upon examination brain atrophy, sclerosis, tumors and other abnormalities as a result of the primary lesion. These are perhaps the class of cases which fall into the hands of the surgeon in the course of years and upon which he will endeavor to decide as to whether he will obtain any results should he operate. Should I undertake to answer the question for the surgeon I should make answer, after a careful and sober-minded scrutiny of my own cases and the published records of men who have done any extensive work in this line, by saying unhesitatingly, you will get no permanent benefits whatsoever by craniectomy in this class of cases.

Again, we see a class of epileptics where we find, upon a trephining, a well-defined cicatrix upon the cortex, which presumably is the epileptogenic nidus. While there is but little difficulty in removing this cicatrix, yet the impossibility of gaining a healing without the formation of a *new* cicatrix prohibits the expectation of a cure in such cases.

The foregoing comprise in the main all the causes which form any excuse or promise for craniectomy. The general practitioner as well as the surgeon has discovered that *any* pronounced change in the patient's habits or environments will for a time cause a cessation of the attacks, and it is doubtless due to this that many a surgeon records cases as cured when three or four months had elapsed without a seizure. No case should be regarded as cured unless freedom from attacks has been observed for at least two years.

In appending the recital of a few cases I do so first to illustrate the apparent causes of epilepsy as discovered upon crani-

ectomy; second, to show the uselessness of operating, and third, for the purpose of recording such cases.

A young man of 22 years received into the side of his head at the anterior parietal region and following the parieto-occipital fissure, a load of buckshot from the accidental discharge of a gun. A piece of the skull, one by two inches, was removed, and the wound healed. Two years from said injury he came to my hands with a well-established epileptic habit. There was no osseous protection over the injury, it was clearly a case of traumatic origin. I dissected the adherent scalp from the cicatrized cortex, removed two buckshot and replaced flap, but endeavored to prevent adhesion to the cortex. No attacks for two months (had been almost daily); gradually they returned; was again operated upon in New York; same result; is now a confirmed epileptic.

Two cases of children, confirmed epileptics; trephining; no apparent cause. One had no attacks for a year, has had less since then than before operating, but is not cured. Second, not benefited.\*

The following is a case of rare interest: Mr. M., æt. 45, farmer, ordinary good health. Mother died of cancer. Three months previous he noticed his left arm did not respond to nervous impulse as normal. Two months later began having severe headaches, with almost total loss of power in left arm. A week later left leg was affected; at that time there was no choked optic disk or other index of optic neuritis. A week later there was marked choked disk and ankle clonus, which did not exist previously. Patella reflex exaggerated. There had been no well-marked epileptic attacks, but slight seizures in which he would turn or fall to the left. The compressing power of the left hand was 15 pounds, that of the right hand 35 pounds. No impairment of intellect. Pain intense on the right side of head. Upon consultation with an ophthalmologist and a neurologist, the diagnosis of tumor of left arm and leg centre of cortex was made. Upon opening over that centre, a well-defined tumor presented just beneath the dura. It was removed with some difficulty, owing to haemorrhage. This I controlled by passing ligatures armed with needles underneath the vessels and thus ligating them. His recovery showed marked improve-

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\* Both cases were boys and had been previously circumcised.

ment in leg and arm movement. In two weeks he became worse and died a month after operation. The autopsy revealed six sarcomatous tumors in the right brain, varying in size from a walnut to an orange.

Strange to say, in two months a case, so similar to the one just mentioned came to me, that I need not detail the history. There was, however, in addition, total blindness and partial deafness. A similar operation revealed a like condition but smaller tumor. She died in three weeks, not having shown any marked improvement by the operation. In both these cases it must be stated that death did not result from surgical causes.

The next case was one of those delusively encouraging kind which show such brilliant cures that the operator, in his first gush of enthusiasm, can write volumes upon the cure of epilepsy. But just as his volumes are going to print he learns his patient has not stayed cured. A young man 26 years old began having attacks in childhood. When I saw him, six months ago, the seizures were almost continuous and were of the true Jacksonian type. Both memory and speech were badly impaired. An opening was made just forward of the Rolandic fissure. A very unusual pressure was manifest, so that a large area of bone was removed. The improvement for three months was something marvellous, not one attack, speech almost perfect and memory but scarcely affected. Then one attack, then another, and to-day there is but little manifest change as compared with former condition.

The last case is one of twenty years' standing in a man 47 years old. No attacks till after he was struck in the right occipital region by a horse's hoof. The seizures have gradually increased in frequency till at present they are daily. They are not, however, of the Jacksonian type. As the nature of the attacks did not indicate pressure or injury in the occipital region, I determined to trephine at a point diametrically opposite in the cerebrum, where we might look for the lesion if there had been much concussion at the time of injury. There was little appearance of pressure upon removing the bone and the dura was not incised. He recovered rapidly from the operation, and, like the preceding case, showed temporary improvement, but at this writing he has relapsed into his former epileptic habit.

It is possible that we shall yet find surgical measures that will bring relief to this most unfortunate class of human beings, but from the light of the work done in this line and the results obtained, there is but the faintest encouragement to continue performing craniectomies for the cure of epilepsy. Perhaps when the veil has been a little more withdrawn and we get a longer glimpse of the occult sciences of telepathy, spiritism, magnetism and such influences as govern nerve impulses and nerve impressions, we shall understand how to avert the transmission of such psychical influences from parent to child as cause a disturbance of that delicate balance of nerve centres whose equilibrium is health.

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#### THE TECHNIQUE AND INDICATIONS FOR SUPRAPUBLIC CYSTOTOMY, WITH CLINICAL CASES.

BY EDWARD S. GRIGSBY, M. D., WILLIAMSPORT, PA.

(Read before the Trousseau Medical Club, of Philadelphia, May 8, 1896.)

THE anatomical points to be remembered are simple, and the operation, if advantage be taken of the relations of the parts in question, is not a difficult one.

The points to be considered are the bladder and the structures above and below it—those above, because through or about them we must pass in order to reach the bladder, and the parts below, because by means of them we may gain the advantage of position.

As epicystotomy is so seldom performed on the female, we will confine our considerations to the male, remembering, however, that the intervention of the uterus, with its appendages, between the organs in question, does not alter the technique.

Normally the bladder is situated in the anterior lower part of the pelvis, just beneath the pubic bone. It is roughly divided into a fundus, body, base, and neck. When empty it is triangular in shape, the fundus resting slightly below the upper border of the symphysis. When moderately distended the fundus rises somewhat, but when greatly distended, as from long retention, it may go as high as the umbilicus. Ad-

vantage may be taken of this possible change of position when operating, as will be shown later.

The peritonæum, the most important organ to be avoided in the operation, is attached to the bladder at its summit, extending on the anterior surface as far as the remains of the urachus, then being reflected upon the abdominal wall. Its attachment to the bladder is firm, but to the abdominal wall quite loose, thus allowing for the expansion of the bladder when over-distended, and also permitting of this fold being pushed up out of the surgeon's field with the handle of the scalpel, finger, or other blunt instrument. Posteriorly the peritonæum descends between the bladder and the rectum, much lower than on the anterior surface.

Below the anterior reflection of the peritonæum is the pre-vesical space, or cavum Retzii, which consists of loose connective tissue and fat. Going upward, we have the tendinous attachment of the pyramidales muscles to the upper border of the pubic bone, then the linea alba, and lastly the fat and skin. Below we have, as before stated, the posterior reflection of the peritonæum and then the rectum.

#### THE TECHNIQUE OF THE OPERATION.

The pubes should be shaved, and the usual antiseptic precautions for any operation where infection is liable to follow should be observed. The rectum should be emptied a few hours prior to operating. The patient, being relaxed by means of a general anaesthetic, should be placed in the Trendelenburg position if possible. This is most advantageous, for gravity naturally assists in disposing of the dangerous peritonæum, and also somewhat raises (in reality lowers) the fundus of the bladder, nearer the upper border of the symphysis. This position renders distension of the rectum unnecessary. But should it be impossible or impracticable to adopt this position, should it be necessary to operate on a bed, then distension of both the rectum and bladder, with slight elevation of the hips, may be resorted to.

The distension of the rectum is accomplished by means of "Petersen's rectal colpeurynter," which consists of a rubber bag, oblong in shape, with a tubal extremity. This is well oiled and inserted into the rectum above the sphincters. It is

distended by gently forcing in warm water, with a hand syringe, eight to ten ounces as a rule being required in the adult. *Gently* and with a hand syringe are precautions that should not be ignored, for serious damage may result by recklessly distending with a fountain syringe. The tension of the organ is in this way recognized by the operator and danger of rupture avoided. The distention of the rectum forces the peritonæum up, but does not influence the position of the bladder to a marked degree. Now, if the bladder be moderately distended with ten to twelve ounces of warm boric acid solution, after drawing the urine and washing the viscus, which precaution should always precede the operation, the fundus is forced up, and the peritonæum still more, the result approaching that obtained by the Trendelenburg position. This is known as the Carson-Petersen method. Dittel distends the bladder with air.

The patient being placed in the desired position, the incision is made, extending from the upper border of the symphysis, in the median line, towards the umbilicus for from two to four inches. Cutting down through the linea alba, the tendinous attachments of the pyramidales muscles are nicked, keeping close to the under border of the pubic bone, the prevesical space is reached. The connective tissue and fat here are cut as little as possible, but carefully teased upward with the handle of the scalpel or the finger, thus pushing before it the anterior fold of the peritonæum, until the bladder wall is exposed. By letting the prevesical fat remain intact as much as possible, the chances of infection by infiltration are much reduced. The bladder wall being exposed, it is hooked with a tenaculum and an incision made large enough to admit a finger, which is thrust in and the cavity thoroughly examined on its inner surface. The extent of the bladder incision is governed by the conditions found within, likewise the immediate suturing of it. If the conditions are such, as after the removal of a calculus which has not injured the internal coat, that it is deemed advisable to close the incision, a Lembert suture of fine silk should be used. The completeness of the work may be tested by C. M. Thomas's method, of gently distending the bladder with water or air, and observing any leak that may exist. The external wound is partially closed, a drain of iodoform gauze being jus-

tifiable, especially if the prevesical fat has been much injured, and also in consideration of the fact, that should infection take place, the bladder wound is well down in the pelvis, and not accessible.

Most cases, however, will require drainage and frequent washing of the bladder, and healing to take place by granulation. In draining one or two tubes may be used. One end of the tube is placed in the bladder at the neck, and the other secured in some manner to the outside, either by means of a stitch or by packing gauze about it. Capillary drainage with iodoform gauze has been successfully employed. It is claimed that draining the bladder by means of the upper cut is more efficacious than by the lower or perineal section, and in addition the advantage of less danger from infection, and also that the patient is not required to remain so constantly on his back, but may after a week's time be allowed to sit up.

Senn recommends, especially in cases of septic cystitis, that the operation be done in two steps, the first, after the described method, until the bladder is exposed. Iodoform gauze is then thoroughly packed in the wound, and bichloride gauze with a few adhesive strips for an external dressing. The dressings are left in place from four to six days, and when removed, granulations will have sprung up, thus occluding the lymph spaces, and rendering absorption of the septic material from the bladder impossible. The second step may be done without a general anaesthetic; a staff is introduced into the bladder and the cut through the wall made upon it.

Anchors of heavy silk sutures may be introduced, and when irrigating the bladder in the subsequent treatment render the drawing up of the viscera possible both for inspection and to render washing more perfect.

The exposed wound surfaces will often become, after some days of treatment, coated with fine calcareous deposits, going on to quite thick incrustations. These may be picked off carefully, or will disappear in time, especially with the aid of a very weak solution of muriatic acid.

#### INDICATIONS FOR THE OPERATION.

Epicystotomy is indicated in vesical tuberculosis; vesical calculi, when they cannot be crushed or are too large to be

removed by perineal section; tumors of the bladder; for drainage in chronic cystitis (septic); for the removal of enlarged prostate, or a permanent fistula if this is not feasible; in unsuccessful attempts at perineal section; for the repair of some cases of vesico-vaginal fistula (Trendelenburg).

The clinical cases which I present are all from the practice of Dr. W. B. Van Lennep, who has kindly permitted me to use them in connection with this paper, and the symptoms preceding the operation, the treatment and results following, are taken directly from his record books. In the capacity of assistant to him, I have been actively associated in each operation as well as in the after-treatment, so that practically a personal experience is given.

CASE I.—Septic cystitis, septicæmia, tumors of lateral prostatic lobes. Mr. C., 55 years. First came to the office March 24, 1896. Was exceedingly prostrated and very thin. Assistance was necessary for almost every move he made. Had been suffering for months, and came to Philadelphia from Williamsport determined to get relief at any cost. His symptoms were: Pain on urinating; on moving; attacks of retention; stream lacks force; often dribbles; blood only when catheterized; pain running from bladder up to right loin; retraction of testes; frequently has chills preceding aggravations of pain; urine very cloudy. Patient was sent to the Hahnemann Hospital, diet to consist of plenty of milk, vegetables, Poland water exclusively, and but little meat. Urine of twenty-four hours to be saved for analysis.

March 25th.—Visit. Temperature, 103.8°; great deal of abdominal pain; this was relieved by glycerine and turpentine enemata. Urinalysis shows quantity, 35½ ozs.; sp. gr., 1015; acid; cloudy; albumen by all tests; scope shows pus cells in great quantity; round and irregular epithelial cells.

March 27th.—Operation, P. O. R. Hospital. Trendelenburg position, epicystotomy; suspension suture of silk; marked enlargement of the prostate found; middle lobe especially so; several hard nodules in left lobe were turned out after incision of the lobes; tube drainage; prevesical pack, sublimate dressings, adhesive strips. Patient somewhat shocked after the operation, due to his weak condition.

March 28th, 29th.—Visits. Temperature normal, free from all pain, general condition much improved.

March 30th.—Visit. Removed pack; irrigated bladder through tube; to be washed daily through urethra.

March 31st to April 9th.—Visits daily. Same treatment continued; temperature normal; patient sitting up on lounge; full diet except meat; comfortable in every respect; Dr. Hall, pathologist to the hospital, reports examination of specimens removed from lateral lobes to be a fibroma. To have vasa deferentia tied, in lieu of castration, the suggestion of the latter producing a great moral shock to the patient.

April 10th.—Operation, P. O. R. Hospital. Trendelenburg position; enucleated middle lobe of prostate; incised and removed a number of fibroid kernels from both lateral lobes; double ligature and division of vasa deferentia; close suture and sublimate dressings to scrotal wounds; iodoform gauze pack and tube to bladder.

April 11th.—Visit. No reaction whatever; some urine passed through urethra; temperature normal.

April 12th to 17th.—Improvement continued and patient sent home with complete relief of all urinary trouble. Suprapubic fistula to heal by granulation.

CASE II.—Putrid cystitis. Mr. S., 67 years of age. Consultation April 11, 1896. History of enlarged prostate; now putrid cystitis, and symptoms of stone; sounding negative. Recommended washing two to four times daily with boric acid and chloral hydrate solution.

April 17th,—Consultation; urine improved somewhat for first few days, then relapsed; gradual failure in strength and appetite; advised exploratory opening of bladder in two tempos.

April 18th.—Operation, on bed; hips elevated; median incision and pushing up of prevesical fat, exposing bladder; cavity packed with iodoform gauze; sublimate dressings, and adhesive.

April 19th, 21st.—Visits. Patient much prostrated; to be stimulated; good reaction followed.

April 22d.—Operation, second step. The pain being too great to permit of completing the operation without an anaesthetic, ether was given. A staff being introduced, the bladder was opened upon it. Bladder was found very much contracted, barely admitting top of finger; enlargement of three lobes of the prostate; enormous pocket to left and pos-

teriorly; much larger than cavity of bladder, and filled with putrid urine; introduced tube into pocket and washed thoroughly; iodoform gauze and sublimate dressings.

April 23d.—Visit. Profound shock, from which he has rallied under stimulation. Pocket to be washed twice daily.

April 24th, 25th.—Visits. Reaction good; apparently improving; continue same treatment.

April 26th.—Visit. Uremic coma has developed; cup. ars. prescribed.

April 28th to date.—Visits. Delirium gradually disappeared under cup. ars.; washings continued as before; patient is improving daily; able to sit up on lounge. Note: Pocket has practically disappeared. Patient is up, out, and apparently well.

**CASE III.**—Epicystotomy after failure to reach the bladder through the perineum. Patient had been suffering from retention for several days; had been tapped a number of times by his family physician, the sites of the punctures indicating that the fundus of the bladder must have reached near the umbilicus. Heart was intermittent, and there existed also a mitral regurgitation. Impassable stricture in bulb, due to an enormous cicatricial mass,  $1\frac{1}{2}$  inches long, both urethral and periurethral. Perineal section was done; the urethra opened anterior to the stricture, by the Wheelhouse method. Failing to find the opening, Cook's method was tried. Failing also in this, no time was lost, on account of the patient's condition, and epicystotomy was done. Retrograde catheterism was practiced with a curved conical sound, and the urethra found displaced well to the left by traction of the cicatricial mass. Tubes were introduced through the perineal wound and above pubes. Time of operation, twelve minutes. Complete relief from all pain. Absolutely uneventful recovery.

**CASE IV.**—Vesical tuberculosis. This case was treated at the Hahnemann Hospital. The symptoms were: Intense prostatic pain; frequent urination; occasional passage of a little blood; progressive emaciation. Sounding negative; examination of urine showed the presence of blood and tubercle bacilli.

*Operation.*—Epicystotomy in Trendelenburg position; examination by the electric light introduced within the bladder, and by the "Caisson" method. Several ulcers were found in

the trigone, and curetted thoroughly. Iodoform-gauze pack, 25 per cent. (Miculicz or umbrella method). Uneventful recovery and complete cure.

CASE V.—Encysted stone of the bladder. This was one of those rare cases the recovery from which, to the laity, seems little short of a miracle. The patient, 50 years of age, was as near death from his suffering as one could be; emaciated, no strength whatever, and with little hope of relief. His symptoms were decidedly those of stone, yet, though sounded repeatedly by competent men, no stone could be detected. Stone was found, epicystotomy determined upon, and in the Tredelenburg position this was quickly done. Examination with the finger in the bladder revealed a large encysted stone, which accounted for previous failures to find a calculus with a sound. It was with some difficulty removed, and the usual after-treatment observed, the bladder being frequently washed. All symptoms disappeared, and strength and health were soon restored to the patient.

In the five cases reported, no two are alike, and all present unique features:

The first case, for the continued high temperature to be so quickly controlled; he had had a daily rise to 103.8 for some time, yet on the day succeeding the operation it was normal, and continued so.

Another feature of great interest is the profound mental shock he evinced when castration was suggested. Such depression is even more marked after the operation, and in one instance coming to my knowledge was the only explanatory cause of death. This of itself should be a strong argument for the less heroic operation, which attains practically the same result. The result in this case was quite as satisfactory as if castration had been performed, and the patient still has the comfort of knowing he is not unsexed.

In the second case the operation was done in two tempos. When the bladder was opened, and the large pocket of putrid urine was found, the advantage of this plan was keenly appreciated by the surgeon. Infection by infiltration, in such a condition, had the operation been done at one step, could not have been escaped, and, in the patient's weakened condition, would doubtless have proven fatal.

The splendid result obtained from cup. ars. should not be lost sight of. In cases of uræmic coma, following any operation about the urinary tract, it is almost a specific.

The third case is a lesson in quick operating, when perineal section could not be accomplished readily, and it was seen that time would be required to find the opening. Epicystotomy was quickly done, thus avoiding the danger of an infiltration of urine into the loose connective tissue, from prolonged instrumentation. The deaths reported from this complication should be sufficient cause to adopt the quicker and safer plan of epicystotomy, when perineal section is found to be too difficult. The operation in this case took but twelve minutes.

The fourth case presents a positive cure where there was an unquestionable tuberculosis of the bladder, as proven by microscopical examination, by which the tubercle bacilli were found.

The fifth case gives a brilliant result where the operation was done on general principles. A stone was suspected, and was found probably by accident. Epicystotomy was indicated, and when done, examination of the bladder with the finger readily showed the cause of previous failures.

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## THE INJECTION TREATMENT FOR THE RELIEF AND CURE OF HERNIA.

BY C. FLETCHER SOUDER, M.D., PHILADELPHIA.

DURING the discussion following the reading of my previous article on "The Treatment of Hernia," before the County Medical Society, a distinguished member asked me to report the cases I had treated. To do so would not give as much practical information as giving a description of a few cases, for what was accomplished in those can be, has been and is being accomplished in similar ones.

Mr. W.; student; age, 20; height, 5 feet, 8 inches; weight, 155 pounds; kind, complete L. indirect inguinal; size, medium; years ruptured, fifteen.

He received the first treatment in March, '94, and the last in May. He had never worn a truss, and has not for over fifteen months. At college he took part in the athletic exercises and

college games, and during the summer worked on his father's farm. When examined less than a month ago there was no rupture.

Mr. E.; commission merchant; age, 46; height, 5 feet 11 inches; weight, 200 pounds; kind, L. indirect, scrotal; size, medium; years ruptured, two.

As soon as he became ruptured he followed his physician's advice and secured a truss. The manufacturer put on a French truss, which prevented the hernia from passing over the pubic bone, but did not prevent it from descending the entire canal and passing out of the external ring. As soon as he stood up the rupture would come down, which caused so much pain that he frequently had to stop work. As it never extended below the pad except when coughing, stooping or lifting heavy articles, he could not imagine the cause of the pain. From the examinations I've made, nearly 50 per cent. of those wearing trusses were in a similar condition, and in many cases wearing worse than none. He received seven treatments, the last being in May, '95. During and after August of the same year, when not working, he went without the truss, and has not worn any for the past few months, and at the present time appears to be permanently cured.

Mr. S.; age, 50; height, 5 feet, 5 inches; weight, 215 pounds; kind, L. indirect, scrotal; size, large; years ruptured, thirty.

He had been so unsuccessful in securing a satisfactory truss, he had not worn any for a long time, although the hernia caused him much pain, also annoyance, as it was so large it could be readily seen when walking. Considerable difficulty was experienced in fitting a truss. He has not received treatment for over two years, and goes without a truss, but has not dispensed with it entirely, preferring to wear one, although there are no indications of the trouble returning.

Mr. B.; age, 50; height, 5 feet, 5 inches; weight, 190 pounds; kind, R. indirect, scrotal; years ruptured, thirty.

He had several of the best trusses, but never had one that would retain the hernia when coughing or stooping. For five months he and I worked, planned and experimented, before we succeeded in fitting a comfortable truss that would retain the hernia under all conditions. I have fitted trusses on the worst cases, but was never baffled so before. We had failed so often,

I dreaded to see him come into the office for fear it would be the same old story. Many times I felt that we would never succeed, and it was only his good nature, kind words and determination to obtain relief from the torture he had been enduring that encouraged us to try again. Success finally crowned our efforts. Less than two months afterwards he was able to stand up and cough as hard as he could, go down stairs and return, pick up heavy articles without any truss on and without the least sign of the hernia returning. Two months later he had a very severe attack of pneumonia, accompanied with violent paroxysms of coughing, and during the entire attack wore no truss. Two months after his recovery I detected a slight rupture, but he had not felt any, although he had been going without a truss. Had one been worn during the sickness, most likely the hernia would never have returned, as the parts were not strong, and his lowered vitality had a tendency to weaken them, besides, he had only received one strong treatment. This case is mentioned to show the difficulty that is sometimes experienced in fitting a truss, and the importance of wearing one till the parts are firm.

To properly fit a truss requires skill, and unless it be so applied, the treatment will be a failure, no matter how skilled the operator may be. Of the various trusses I've seen, I prefer a modification of the Hastings No. 144 A.

A few cases have been reported in medical journals within the last five years where serious results have followed the injection treatment. I have endeavored to find the cause in those cases, and from the best information received, the physicians giving the injections had not had experience, or had not taken proper antiseptic precautions. The mortality following the surgical operation, at the present time, by skilled surgeons, has been reduced to 1 per cent., but would it be as low if physicians without special preparation should attempt to perform herniotomy?

The greatest setback the injection treatment ever received in this city was caused by a self-titled "doctor," who had never received a medical degree. A physician who was present at the time told me the man used no precautions before giving the injection. Peritonitis followed, it is claimed, and it was soon heralded by all the daily papers and magazines throughout the country that a Mr. P. had been injured for life by the injection

treatment. *I have given over one thousand injections of a similar fluid without any serious results.*

Statistics from the U. S. army reports claim that one out of every eight men examined was ruptured. At a low estimate there are over 100,000 ruptured people in Philadelphia.

Of the various treatments, the surgical operation and injection method are the only ones at the present time that offer any degree of certainty of effecting a cure. Two physicians in Cincinnati claim they can cure 95 per cent. of all cases of rupture. One uses the surgical operation, the other the injection method. The laity and many physicians are unjustly prejudiced against the former, and at least 75 per cent. of those afflicted will not consent to a surgical operation unless in case of strangulation. To such persons, until recently, their only hope has been in being able to secure a comfortable truss, but the majority of them would be anxious to obtain relief or cure, if they knew the efficacy of the injection treatment; besides, it has the additional advantages of requiring no anaesthetic, no cutting, no loss of time from business, and where a complete cure cannot be effected, they can be made comfortable.

Past experience in treating 120 cases of the following variety has convinced me that all uncomplicated cases of complete, reducible, indirect, inguinal hernia in healthy men, with a sufficient lower wall to build upon, can be cured, but do not believe all will be able to dispense with a light truss. So thoroughly do I believe the above statement is not over estimated, that I am willing and anxious to treat as a test case for any representative body of physicians or society, the worst case to be found. I do not believe all cases of all kinds can be cured, but the percentage of those that cannot be practically cured and rendered free from danger of strangulation is very small.

As far as the fluid is concerned, it's my impression that most any antiseptic fluid that will set up sufficient irritation will secure results. The more irritation that is produced, the stronger and more permanent will be the results, and the less number of injections required to effect a cure. I have been successful with the following formulæ:

R. Fld. ext. quercus alba,	. . . . .	fʒj,
Alcohol, 95 per cent.,	. . . . .	fʒij,
Carbolic acid,	. . . . .	gts. ij —M.

Sig.—Reduce one ounce of the *quercus alba* to one drachm, by boiling. Inject 1½-3m.

R. Sulpho-carbolate of zinc, . . . . . gr. x.,  
Alcohol, 95 per cent, . . . . . 3j.—M.

Sig.—Dissolve the zinc in a few m. of boiling water. Inject 8-15 m. once or twice a week.

The injection treatment has not been extensively used till recently, although it has been highly recommended by the best surgeons. Prof. John A. Wyeth speaks of it in his latest surgery as being "the simplest in execution, involving less danger and annoyance, and offers fully as great a prospect of success." The time is not far distant when this treatment will be as general and more favorably endorsed than vaccination is at the present time.

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#### PROSTITUTION—NO LICENSE, BUT PROHIBITION.

BY G. MAXWELL CHRISTINE, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Philadelphia, May 13, 1896.)

It is not easy to get at the precise number of prostitutes in any great city. Most estimates are the sheerest guesses, and are very wide of the mark. The ordinary figure given for London, for example, is from sixty thousand to eighty thousand. . . . It has been declared that in New York City there are between forty thousand and fifty thousand such women. That would make one habitual prostitute to every nine mature men in the city. And as it is estimated that every fallen woman means on the average five fallen men to support her, it would appear that more than half our men are regular contributors to the brothel, which I should very much hesitate to believe. . . . An army of twenty such hapless creatures is ghastly enough not to need exaggeration. Estimates of the number in Philadelphia run all the way from fifteen hundred to ten thousand. The estimate of fifteen hundred is based on there being three hundred houses of ill-fame in the city—five girls to a house being a fair average. But I can find without any difficulty three hundred such houses in the district between Sixth and Broad streets and Arch and Green streets. There are not less than one thousand such houses in the city, and as many as five thousand women live among us by the sale of their bodies. This does not, of course, include the vast multitude of poor girls whose labor yields scarcely enough to keep body and soul

together, many of whom fall victims. . . . Mr. Crittendon estimates that there are two hundred and thirty-two thousand prostitutes in our country to-day. Their average life is five years. Ancient and heathen Athens used to go into mourning because every nine years seven youths and seven maidens had to be furnished for the devouring Minotaur of Crete. How ought we, then, as a nation to prostrate ourselves before God in seeking deliverance from this monstrous evil that every year devours forty thousand of our pure maidens and pollutes two hundred thousand of our pure youths!\*

Respecting thought on the subject of prostitution, there may be said to be three classes of people—one class protesting against it, one favoring it, while a third is indifferent to it, and entertains no thought regarding it one way or the other.

It is possible that members of each of these classes are present this evening. It is safe, therefore, for me to expect that some will commend the title of my paper, some will condemn it, and others will express no opinion respecting it, preferring to stand off at a respectful distance from the subject. It is so concerning every phase of the public morals; there will be differences of opinion which are difficult to harmonize. Moreover, there are questions, even of public and private concern, which by common consent or instinct are referred to only with bated breath, as though the mere mention of them was pollution. And yet the mere fact of this existence of a difference of opinion, and, in a measure, of the repulsive character of the subject of my paper, evidences the real necessity of its discussion before a body of men professing to be conservators of the public health.

It is not so much because prostitution is an infraction of divine and human law that I refer to it to-night, but more particularly because it entails so much misery and suffering on innocent women, to whom infection is carried, with all its attendant results.

As in the liquor question, there are men and women who do not find in the injunction, "Look not upon the wine when 'tis red!" sufficient command to abstain from alcoholic drink, so do we observe regarding prostitution that, though fornication and adultery are forbidden by divine command and interdicted

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\* From "The Social in Philadelphia," by Rev. Frank M. Goodchild, in *Arena* for March.

by human law, there are those who say, evil though it be, it of necessity must be!

But however strong the moral argument against prostitution may be, I will devote little consideration to this part of the question, but will endeavor to direct the force of what my thoughts are on the subject towards its sanitary consideration. Aside from the moral question at issue, we have the equally great one of its effect on the health, the life and the happiness of women.

We devote much time and consideration to the various means of diagnosis and treatment of disease-conditions arising from venereal infection of women; but I doubt whether we give sufficient thought to the eradication of the causes of the propagation of this infection. It is not to be expected that this bureau can so consider the subject to-night as to effect any proposed reform; but it is reasonable to expect that the sentiment expressed here will have some force in fashioning sentiment and will assist in solving one of the most intricate of social questions.

This paper was suggested to me by the effect on my mind of a conversation had the other day with a friend, who stated that he believed there were good and cogent reasons why prostitution should be licensed. I can hardly credit that there are such good and cogent reasons; but I do know that there are many of our best citizens who favor licensing bawdy houses and bringing them under some form of legal protection. But those who have observed popular sentiment in this city for, say the last twenty-five years, and have appreciated its full strength in the direction of a progressive moral healthfulness, will hardly dispute with me the belief that Philadelphia will never be saddled with a legalized or licensed prostitution.

That this subject has a place in our discussions, let me quote from the words of the late Dr. Goodell, to whom women in this country should rear a monument for the good he has done them:

“ Undoubtedly some of the worst forms of women’s disease come from the three following causes: The specific infection of wives by their husbands, criminal abortion and the prevention of conception. So long as society condones in man such lapses of virtue as it peremptorily and pitilessly condemns in woman,

so long as chaste woman is willing to take to herself an unchaste husband, so long will young men indulge in illicit sexual intercourse. As a too common result, men, soon after their marriage, often on the honeymoon journey, unwittingly infect their wives with the venereal diseases which, years before, they may have caught, and of which they honestly believed themselves to have been cured. Specific blood-poisoning in all its harrowing forms will occasionally be met with; but gonorrhœal infection is far too common—so common in some classes of society as to be a veritable matrimonial scourge. From this cause come very many cases of sterility, miscarriage, oöphoritis and salpingitis of every kind and degree, pelvic and intestinal adhesions, chronic ill-health and even death."

So wrote the great teacher. If all gynæcologists, after years of active service, would sum up their experience, as did Goodell in the last two or three years of his life, giving a careful résumé, in which mistakes are admitted and conscience is added to skill in the summation of results, gynæcology would advance many steps toward a greater trustworthiness.

When we meet with any of the diseased conditions to which Dr. Goodell refers, we cannot refrain from wishing we had it in our power to restrain the cause. In an endeavor to arrive at some conclusion as to how much of this infection is attributable to houses of prostitution, I have made some inquiries, but have been unable to secure any reliable statistics, yet I venture to state that the greater part of it is so obtained. Another point of interest to me has been the relative proportion of single and married men who contract gonorrhœa and syphilis. I have obtained no data on this, but in my practice at least one-fourth are married. How many of these carry infection to their wives it is impossible to say, and yet the woman who escapes getting infected from her gonorrhœal husband is indeed fortunate, for the chances of escape are very small. Once a woman is infected, we have the dangers of a long train of diseased conditions with which you are all familiar.

I am aware that much of the venereal poison is gained privately, against which there can be no efficient legal protection. It is probable that this will always exist, and there seems to be no way for its regulation, except in the general education of women, even of the type calculated to spread the infection, to

be cleanly, and of men to be cautious. But it would appear to me that there ought to be some means for the lessening of the opportunities for infection—those at least which the law can reach and control. No church could justify itself in setting up a dance hall in its own building in an attempt to keep other dance halls from thriving, nor does it seem logical for us to supinely rest under the imputation of condoning prostitution, because it is one of the evils that will exist either publicly or privately, and if we seek to lessen it publicly we tend to increase its private operations. It is natural that we should be careful how we suppress a public evil, for fear we drive it into private places where the harm may be greater, but as to how far this should control us in the consideration of this subject I may have a few words to say further on.

As I have looked at the subject, we might ask ourselves the following questions :

1. Shall we leave the solution of the problem of prostitution to time, and the conditions that time imposes ? In other words, shall we let prostitution alone to work out its own salvation ?
2. Shall we throw the city open to the prostitute, permitting her to settle where she will, so long as she does not disturb the peace of the neighborhood as we ordinarily understand it ?
3. Shall we enact laws for the sanitary regulation of prostitution ? In other words, shall we license prostitution, placing it under sanitary and police control or supervision ?
4. Shall we make prostitution prohibitory under the law ?

These four questions open the way for free discussion, which it is mainly the object of this paper to arouse and stimulate tonight.

*First.* Shall we leave the solution of the problem of prostitution to time, and the conditions that time imposes ? In other words, shall we let prostitution alone to work out its own salvation ?

There are persons who honestly believe that the man or woman who chooses to open and conduct a house of prostitution ought to be given the right and privilege so to do, and that if there are women who wish to ply the trade of the prostitute, it is their lookout, and no one should interfere. This is a free way of thinking, but it exists, strange as it may appear. It is on a par with the thought that in a country assuming to

be free those people would be enjoying true freedom who are privileged to disregard all law in the gratification of an unbridled appetite and desire. Free love and socialism in this country are reminiscences!

*Second.* Shall we throw the city open to the prostitute, permitting her to settle where she will, so long as she does not disturb the peace of the neighborhood as we ordinarily understand it?

This would assume that the same condition of things would exist respecting the evil that existed some years ago respecting the sale of liquor, when any one so choosing could open a saloon, and when it was a rare occasion that the law was strong enough to close it. Until forty-eight hours ago I thought this was the case in this city respecting prostitution, from the fact that the number of bawdy houses was great and that they plied their business so openly. I assumed that prostitution in this city came under the law only when the peace and quiet of the neighborhood was disturbed. But in consultation with one whose duty it is to administer the law I learned that every bawdy house in operation in this city was in defiance of the law.

I think we can pass over this second question as we did the first, and conclude that an enlightened civilization protests against any such semi-free license as this question would imply.

*Third.* Shall we enact laws for the sanitary regulation of prostitution? In other words, shall we license prostitution, placing it under sanitary and police control or supervision?

Evidently, to act affirmatively on this question, would be to have the State commit itself to the acknowledgment of the necessity of the evil of prostitution. To enact such a law would be to make the commonwealth an ægis behind which the brothel-keeper could find protection. Such a shield would open the way to abuses, which would do much towards propagating the evil.

I can never be brought to the belief that there is any necessity for the existence of a bawdy house nor of prostitution. I cannot agree that a Gunner's Run should pollute the air of the city through which it passes, nor that the slums should remain to blot any city or part of a city, nor that crime and misdemeanor of any kind should be permitted to be practiced anywhere on the civilized earth if it can be prevented. The Con-

stitution contemplates "peace and good-will to all men," and to this end the trend of human effort has been to establish peace and universal good-will among all men, to secure which all things must be brought under the mandate of the law. A hundred and twenty years has brought order out of chaos in this country, and as we have watched the process of formation and reformation we have seen more and more that the inevitable warfare between good and evil must finally end in the elevation of good and the debasement of evil.

Going back twenty-five years and more, I recall a condition of things in this city that beggars description. Then harlotry flourished in almost continental glory. Reform has caused a change to come over the scenes of the debauchery of those days, and harlots have been gradually forced into the realization of the fact that they must conduct their business in more secluded neighborhoods and with less publicity. They are being gradually driven into narrower quarters, to avoid which they have scattered themselves over the city to localities from which they are soon dislodged. "Men of the town" freely admit that the last few years has witnessed a great change for the better in this respect.

In referring to the improvement that has taken place in public prostitution in this city, one is forced to associate this reform with that which has taken place in the liquor habit. The two evils are alike in some respects, but different in others. For instance, both are evils, but the one is fully so, and the other only partly so. Fornication and adultery have always been infractions of the law, but there is no law against a man drinking liquor, provided he does not abuse the privilege and become a nuisance. Hence it is impossible to get a community as large as this to come to an agreement that the sale of liquor shall stop, but it has been regulated, and this is the best that can be done for the present. The evil of prostitution is unlike that of the liquor question, because it is practically only the few that resort to prostitution, and this minority would cut no figure in a vote of the people. This minority—those who act a part in prostitution—are divided into those who resort to it for the variety it affords them and those who are impelled to it for relief. The greater the animal propensities in these men the greater the necessity for relief, and if no relief is afforded them

the greater the danger to innocent women by reason of assault. Those who believe in legislating in favor of prostitution use this fact as an argument, asserting, with emphasis, that if we wiped out prostitution the streets of our city would be the scenes of frequent assaults, and the police of our city would be incompetent to prevent them. For this asserted possibility, then, these advocates of license would maintain under the law a sort of bawdy restaurant where the animal that is in man could find refreshment and relief. In other words, the government must give legal recognition to an evil, because by suppressing it another is given birth and life to, which that very government cannot suppress. A cardinal principle in the making of all law is the assumption that all law can be enforced. The establishment and maintenance of this principle is behind the great progress this country has made, and is the very foundation of liberty.

To enact laws for the license of prostitution would be a virtual recognition by the State of the necessity of prostitution, a confession of its weakness to cope with crime, and an inducement to men to violate their chastity, and it would propitiate the vice of fornication and adultery and favor the open contamination of the morals of the community. More than this, and to get nearer to the phase of the question we are to give greatest consideration to-night, I deny that any system of sanitary or police control or supervision can afford the protection from infection asserted of it. No physician who acts conscientiously will give a woman a certificate of cleanliness and freedom from venereal infection that carries with it any more than an opinion. Indeed, the giving of a certificate to a harlot is a dangerous practice, and is so recognized by many, who refuse to give it under any circumstance, knowing that to prove a woman of the town free from infection the most thorough bacteriological and control tests must be made of the discharges from uterus, vagina, urethra and rectum. Added to this is the theory of latent infection, that which lies sleeping, as it were, finding in the tissues of the woman no fertile ground for development, but attacking with great virulence the urethra of the first man who comes in sexual contact with her. We must also take into account the results of laxity in the examinations, and the fact that a non-infectious vagina in the morning may

be infectious in the afternoon, and a night visitor may be infected. The usual certificate given in good faith in the forenoon has lost its value in the few hours of its existence.

Licensing prostitution affords a fallacious protection, which, it seems to me, does so much harm in the false sense of security it gives men, that it more than offsets the protection it affords in others.

But on what basis of common sense and common justice ought the woman be subjected to the legal exactions a license law would impose upon her while the man comes and goes a free agent, taking and bringing infection without detection? A certificate of cleanliness should go with every man, and the harlot should be protected from the infection he may carry as he asks to be protected from that which she may give him.

I state as an axiom that no medical or police official will be so true to duty under a license law as to make the desired regulation and protection worthy the name, nor carry it beyond the realm of farce.

A certain writer, advocating license, says of it: "With all these precautions, however, it is not possible to prevent entirely the spread of the dire malady which is too often the result of intercourse with public women."

Let us suppose that we had a license law in this city. How many prostitutes would come under its provisions? I am not certain in my figures, but I feel safe in saying that in Paris only one-sixth of the total prostitutes of that city of brothels are registered, while the other five-sixths are free to spread infection without restriction.

But we come now to the fourth question: Shall we make prostitution prohibitory under the law?

This question carries with it all forms of bawdry, and includes fornication, adultery, obscenity, indecent exposure, street-walking, solicitation, and takes in both bawdy houses and bed-houses and all places where bawdiness is going on.

Prohibition is an unwelcome term to the lover of that kind of freedom which permits the freebooter to have his own way; but it is a welcome term to the citizen who rightly interprets the meaning of constitutional liberty.

To prohibit prostitution simply means that the State regards it as a crime; and if the State would justify itself in the matter

of its dealing with the subject, it must prohibit it as it would prohibit the infraction of any rule of conduct which we are morally bound to obey. Under the laws of this commonwealth it is an offence to establish or maintain a bawdy house. The law is explicit in this matter, and sufficiently covers the ground to prohibit prostitution in this city; but practically it does not prohibit. The facts show that either the police are inefficient or that they are lenient. Prostitution exists; and for some reason the police, to whom is entrusted the enforcement of the law, fail to suppress it. I have my grave doubts whether the police are in earnest in seeking a strict observance of the law, and I should not be surprised to learn that in this matter they remind themselves of the saying that "all things may be lawful, but all things may not be expedient."

However near this view may be to the truth, every sincere effort made to suppress prostitution is one effort toward throwing about women that protection which, from her very nature, it is man's duty, and particularly the law's duty, to provide for her.

Take specific infection from among the causes of women's diseases, and we would take away from her the chiefest of them all.

What shall be our voice to-night on this subject?

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POLYNEURITIS IN MERCURIAL POISONING.—Drs. Spillmann and Étienne call attention to the possibility of mercury giving rise to polyneuritis. Though the involvement of the nervous system in poisoning by this drug has been known for many years, the possible sequence of polyneuritis was first pointed out by Ketli, of Budapest. The writers have observed three cases, of which the following is typical. A workingman of thirty-five years who always had been well, in March, 1895, contracted gonorrhœa, with epididymitis. He was treated by a druggist with inunctions of merc. ointment and a "vegetable syrup," which later was shown to contain large quantities of the iodide of mercury. After fourteen days' treatment he was seized with chills, salivation, anorexia, vomiting and violent shooting pains in his left leg. He persisted with the treatment, though the pains increased and an intense and fetid stomatitis was added to his sufferings. Three days later there was complete paralysis of all four extremities, accompanied by violent pains. Only with his right hand could he execute a few movements, but he could not lift his arm. Very violent painfulness to contact, pronounced muscular atrophy, decided stomatitis and a great quantity of albumin in his urine. April 30th he commenced to move his extremities a little and the pains decreased in intensity. No reaction of degeneration. May 14th he could begin to walk and the greatly atrophied muscles began to increase in volume. At the end of August he was about restored to health, though he still complained of a tired feeling in his legs.—*Hospitalstidende*, No. 4, 1896.

## EDITORIAL.

### DISPARITY OF AGE IN MARRIAGE.

Although brought prominently before the public by a species of newspaper enterprise of the Paul Pry order, for which we have anything but admiration, this subject is one in which we, as physicians and as educators, should have an interest, and on which we should be prepared to pass an intelligent judgment.

In considering the question we must leave out of view all exceptional cases, and regard it only as it concerns the general run of mankind. We are, perhaps fortunately, not all in a position to be consulted in cases where considerations of the succession to thrones or to the control of colossal fortunes come into play; most of us will have to do with the far humbler matches of the Smiths and Joneses of everyday life, and will therefore be in a better condition to treat the question on general principles.

Although the original basis of what we now call Love was undoubtedly physical attraction, provided by Nature with special reference to the propagation of the race, in the process of evolution and in consequence of the absence of any pressing necessity to fill up unoccupied places—in a hurry—it has come to be so modified that in the greater number of instances it is founded upon real or fancied congeniality of taste, not necessarily of high or exalted ideals.

In former times, when the education of the sexes was so entirely different for each, we can readily see that their life-lines could run parallel but for a short time, and that, therefore, this congeniality could only be of short duration. Owing to the physical and mental precocity of the female, this period occurred when the man was a few years older than the woman. From the circumscribed domestic life prescribed for the woman both before, but especially after marriage, and the ever broadening and deepening activity of the man, the sense of congeniality tended gradually to become only a fond memory.

The supposed duty of bearing all the children that chance or  
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accident was pleased to bestow upon her, together with the wearing cares of a routine life on a dead level, soon set their mental and physical impress on the wife and rapidly increased the disparity between herself and husband, so that it became the general opinion that at latest at forty a woman was worn out, while a man at the same age was just entering the prime of life. As a natural result, it became the prevailing theory that, in order to be truly mated, the man should be a number of years his wife's senior. How many years has not yet been determined; and we find man, in the pride of his fancied perennial youth, not hesitating to yoke May to December.

But a change is coming over the spirit of our dreams. The education now offered to girls, and the increased number of avenues of employment and enjoyment opened up to woman, have put her more on an equality with her brother and have produced effects which cannot fail eventually to be of the greatest good to the human race. As the most important of all effects we rank the feeling of comparative independence fostered in the young woman. Although she still regards marriage as desirable, it is no longer the *summum bonum* to be obtained at all hazards and as soon as possible. She does not now of necessity require a care-taker, and is not therefore so ready to take the first best one presenting, merely for the sake of gaining a home; she has raised her ideal. The result is that early marriages, before twenty, are becoming rarer, and the chances of healthier, stronger offspring, from maturer mothers, better. At the same time the term "old maid" has lost its terrors and has become almost obsolete, its traditional representatives having died out. This gives a greater number of attractive marriageable women, who formerly would have been expected to live and dress and act as "those having no hope," but who now, with their maturer judgment and riper experience, together with the never-dulled freshness of educated minds, present often greater charms and truer congeniality than the immature "buds." The charming feminine characteristics so attractive in these latter are rendered more so by a depth, a sincerity, a poise, which years alone can give.

From present prospects man will have to look well to his laurels. In spite of the obstacles in her path woman has in the last few decades shown herself capable of entering the lists

with man, and notwithstanding the conventional restrictions with which she is still hampered, she has progressed so far that she is coming to be judged by her work and not by her sex. Within a few more years we will find the "new woman" claiming eternal youth for herself, and requiring that her husband—if she have deigned to cast her handkerchief to some son of earth—should be much younger than herself lest she suddenly find herself burdened with a superannuated help no longer meet for her. We can easily see that from original disposition or early environment true congeniality can be found even now where the woman is several years older than the man. Years alone do not make age. Besides, there makes itself felt in woman at some time in her life the maternal instinct, which, if disappointed for a time of its legitimate object, is bound to find vent in some direction. It is seen most beautifully exhibited in happy marriages where the parties are congenial but where the wife is the elder.

From our present standpoint it seems almost more difficult to justify the marriage of a man to a woman very much younger than himself. She may, indeed, render her husband happy as his "pet," or "plaything," or "sunshine," but she can hardly ever satisfy all the requirements of his higher nature. As to the physical side of the question. Why should the female age physically, sooner than the male in a normal condition of things? It is not so in nature generally. Child-bearing is surely a physiological process, and, as such, has nothing inherently destructive in its effects, but rather the opposite—provided the environments be favorable.

The age of puberty in the sexes being nearly the same, why should there be such a great difference assumed in the length of their active sexual lives? In our limited experience the traditional limit of the forty-fifth year has, in the majority of cases, been far overstepped, and we see in this circumstance an effect of the widened sphere of mental activity thrown open to woman.

We say, give woman happiness—happiness is the reflex of unimpeded energy,—give her opportunity to satisfy her mental aspirations, an appreciative sphere for the development of her emotional nature; let her vary her activities and her energies, and her physical nature will respond to her spiritual emancipa-

tion, and there will then be no more room for talk of physical disability or premature old age.

That this may be accomplished for woman will require the laying aside of many prejudices, the surrender of many traditional views, the eradicating of much hereditary selfishness, in short the remodeling of the present habit of thought of man. Although as at present constituted and under present conditions he is a tolerably fair specimen, there is room for improvement, and when we have a "new man" corresponding to and congenial with the "new woman" then shall we have a new earth which will almost render the new heaven of a Millennium unnecessary.

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#### THE PENNSYLVANIA STATE SOCIETY.

ON Tuesday and Wednesday, September 29th and 30th, and Thursday, October 1st, 1896, the thirty-second annual session of the Homœopathic Medical Society of the State of Pennsylvania will meet in Philadelphia. The meetings of this society of recent years have been markedly successful, but the sessions of '96, associated as they will be with a unique circumstance of peculiar significance which will receive merited recognition by the members of the society and the Philadelphia committee on entertainment—the centenary of the promulgation by Hahnemann of the basic principles of homeopathy—practically the reformation of therapeutics, should make the success of this meeting doubly sure, and of itself should be sufficient inducement to bring all Pennsylvania physicians of the new school to Philadelphia to celebrate in fitting manner this centennial event, which has proved to be beneficial to all civilized people. For since Hahnemann vehemently announced to the world that the calling of a physician is to restore health to the sick, and insisted that there should be a speedy, gentle and permanent restoration of health in the shortest, safest and most reliable manner, according to clearly intelligible reasons, and forced men to realize that it was first essential to discover what is curable in disease and then what is curative in drugs, the therapeutical ideas of every school of medicine have been held up for searching investigation and improved, more or less, for the benefit of mankind.

This being the year preceding the biennial session of the State Legislature, careful consideration must be given to the steps necessary to be taken to obtain control of a State asylum for the homœopathic treatment of the insane. Another subject of importance needing ventilation is the advantages and disadvantages of the State Boards of Medical Examiners. These Boards, together with the State Medical Council, have been adopting measures peculiarly obnoxious to the profession of the State and its best interests. Efforts should be made to assist the State Board of Health to secure an ample appropriation from the State, so that it can carry out its well-defined plans successfully, and do away with the embarrassment of action arising from lack of funds. The laity fails to appreciate the value of health boards until an epidemic is knocking at our door. A successful board, however, must be prepared beforehand, and it is to the physicians of the State that the members of these boards must look for sympathy and support.

A large number of distinguished visiting physicians will be in attendance at this meeting of the State Society, and the members of the Society must be present to properly show their appreciation of the interests of these visiting delegations. The secretary will be made glad by having a large number of applicants for membership.

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#### THE INTERNATIONAL CONGRESS.

On the *News* pages of this number will be found two excellent reports of the Fifth Quinquennial Homœopathic Congress, held in London August 3d to 8th inclusive. One account is by the regular English correspondent of the *HAHNEMANNIAN MONTHLY*, J. Roberson Day, M.D., the well-known children's specialist of the London Homœopathic Hospital, and the other is by a distinguished American physician, Dr. T. J. Carmichael, of Germantown, Philadelphia. Our readers are thus presented with two views of the Congress, and it is easy to perceive that the sessions were successful and enjoyable to a degree that must have been flattering to those responsible for the convention. It was unfortunate that only thirty-eight of the more than one hundred members of the American profession in Europe could rearrange their tours to be present. The unexpected change of

date of the Congress was an error of judgment upon the part of the managers arising from misleading American counsel. It caused great inconvenience to the English physicians, and shut out more than three-fifths of the Americans in Europe at the time of the Congress.

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DR. CHARLES G. RAUE, of Philadelphia, died at his home at 6.15 A.M., August 21, 1896, aged 76.

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**HYSTERIC PARAPARESIS OF THE LOWER EXTREMITIES IN A CHILD.**—Dr. Leick (Greifswald) recently observed a boy of eleven years hereditarily entailed, and who after having suffered for several days from a violent toothache, was seized with hysterical paraparesis of the lower extremities. He complained of giddiness and somnolency, with pronounced paresis of the legs. Besides these symptoms there were augmented patellar reflexes as well as paresthesia in the form of sensations of as if ants were crawling over his legs; otherwise no anomalies. Treatment consisted in warm baths and faradization, which brought about a cure in three days after the affection had been treated, in vain, for fourteen days outside of the hospital. —*Deutsche Medicinische Wochenschrift*, No. 12, 1896. [Drs. P. Blocq and Onanoff.—*Semeiologie et Diagnostic des Maladies Nerveuses*, Paris, 1892, p. 294—divide hysterical paraplegia into two varieties. It begins usually with a convulsive attack, or after a slight traumatism, attended with intense disorders of sensibility, while the sphincters are unaffected; it varies in its intensity, and is amenable to treatment by measures which affect sensation and sometimes by hypnosis. At the same time it is associated with hereditary entailment and the stigmata of hysteria, hyperesthetic plaques or areas, attacks and disturbances of sensation. It has been confounded with Pott's paralysis.—Eds.]

**THE CLINICAL SIGNIFICANCE OF CERTAIN RÄLES SITUATED ON ONE SIDE OF THE THORAX.**—Dr. Moncorge (Lyons) has studied two varieties of räles, one situated on the left side of the chest and the other in the right axillary line, which, on account of their appearing in those with excellent health, may be confounded with the signs of grave diseases.

The räles situated at the base of the left lung are very frequent in incipient emphysema, especially in youthful subjects. They are moderately subcrepitant, not numerous, and seated in the posterior-inferior region of the lung, and rarely extending into the axilla. They may also be fine and subcrepitant, when they indicate an emphysema a little more advanced, but even then one will not detect a modification of thoracic vibration nor of sonorosity on percussion. These räles may be confounded with congestions of the base of the lung following grippeal pneumonia or with the superficial and transient basic pulmonary congestion of Bright's disease. From the former they are distinguished by the absence of dulness on percussion, as well as of neuralgiform pains, and from the second by the non-existence of albuminuria and the other signs of nephritis.

The räles situated in the right axilla generally are noticed in the fourth or fifth intercostal space, they being of pleural origin and unaccompanied by modification of sonority or by vibration. They may be subcrepitant. These stethoscopic signs are very frequent and are associated with seizures of asthma and diseases which affect the lung and pleura as well as in common diseases of the right lung. They may be detected in subjects without a hereditary history or personal antecedents, and, on the contrary, they are often lacking in arthritics. They are, hence, of no diathetic value.

The former variety is explained by the greater tendency of the base of the left lung to congestive states from being exposed to pressure by the stomach and its not being so well sustained by the diaphragm. The latter are dependent upon friction between the pleural layers of the fissures of the right lung.—*Lyon Médical*, No. 6, 1891. [“ Beware of unilateral räles—bronchitis—for they are generally tuberculous,” says Prof. Hanot.—Eds.]

## GLEANINGS.

### GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D., AND FRANK H. PRITCHARD, M.D.

**HEART DISEASES COMPLICATING PULMONARY TUBERCULOSIS**—Prof. Leyden (Berlin) directs our attention to the importance of the cardiac complications of pulmonary tuberculosis as worthy of note. Pericarditis, symphysis of the two pericardial layers, serosa, hypertrophy of the left and right ventricles, again disturbances of function with an irregular or a very small pulse may be noticed; even death from cardiac paralysis may set in at a relatively early stage of the disease. The majority of observers admit the smaller size of the heart as a whole in this disease. Rokitansky's theory as to the mutual antagonism of heart disease and pulmonary tuberculosis has been disputed by many competent observers of late; only in congenital stenosis of the pulmonary orifice has tuberculosis not as yet been noticed. Of late years the bacteriology of this question has been looked into. Tuberculosis pericarditis has been recognized. The myocardium has been regarded as immune, though Leyden in from a half to a third of his cases of miliary tuberculosis has found tubercles in the myocardium. The endocardium and, above all the valves, may also be attacked. The acute cases deserve our notice. Many microbes have been found here, and the question arises whether tubercle-bacilli are able to cause an endocarditis. Leyden, in cases of acute endocarditis in phthisis, has been able to detect the tubercle-bacilli in the vegetations on the valves. One patient who previously had had rheumatic fever, and entered the hospital with advanced pulmonary tuberculosis, presented a systolic murmur at the apex of his heart. The cardiac symptoms increased during the course of his phthisis, so that a new endocarditic process could be diagnosed. Dyspnoea supervened, and a blowing murmur was also audible over the aorta. The necropsy supported the diagnosis, for in the fresh valvular thrombi tubercle-bacilli were found, most often lying in cells.—*Hospitalstidende*, No. 5, 1896. [Dr. A. Martha—*Des Endocardites Aiguës*, Paris, 1895—mentions endocarditis associated with pulmonary tuberculosis as a secondary acute variety, but he does not treat of it further. Prof. Osler—*Practice of Medicine*, 1892, p. 94—speaks of acute endocarditis being by no means rare in phthisis. He has met with it in twelve cases out of two hundred and sixteen post-mortems. On another page (218) he mentions it as not a very uncommon complication of pulmonary tuberculosis, it being present in twenty-seven of Percy Kidd's five hundred cases. He also refers here to Norman Cheevers having pointed out that subjects with congenital stenosis of the pulmonary orifice very frequently have pulmonary tuberculosis; this has been supported by other subsequent writers.—Ends.]

**VOMITING OF BLOOD IN HYSTERICS**.—Dr. Herman has given us a full and complete description of this curious and occasional symptom of hysteria. It consists of vomiting of blood, which, when in the fresh state, resembles raspberry syrup diluted with water, but, which in two hours or more, takes on an appearance like that of syrup of rhatany thinned with water. The liquid is viscous and of a syrupy consistency; it is not foamy, as in haemoptysis, nor does it coagulate in the vessel as in haematemesis. This variety of haemorrhage is not accompanied by the usual symptoms of haemorrhage from other causes, yet it is generally associated with dyspeptic symptoms. It usually follows an emotional cause, as a fright, a fit of anger, or sometimes without any cause. Two or three hours preceding it there are noticed a sense of burning in the stomach, which is intolerable and immediately before vomiting there is a pressed feeling, as if a ball were in the epigastrum, with cramps, a sense of strangulation, with beating in the temples, roaring in the ears, dazzled vision, vertigo, etc.

Then the vomiting follows with force, as in an actual effort at vomiting ; sometimes it is accompanied by cough, caused by a sense of tickling in the throat, which coincides with the passage of the liquid. Sometimes this form of vomiting will appear after an hysterical attack. The quantity of fluid is slight ; it may coincide with other hemorrhages or a suppression of menstruation. The vomiting over, the patient feels relieved, the stomach pains disappear, as well as the restlessness.

The cause of the disease is in the nervous system. It is met with usually in women between the ages of twenty and thirty, yet it has been noticed in men as well as in youths. It is equivalent to an hysterical attack. It appears irregularly, after days, weeks, or months, or it may assume a certain periodicity, possibly coinciding with the menses. The prognosis is good, for the quantity of blood lost is slight. In diagnosis one should be on one's guard against malingerers ; then exclude all sources of hemorrhage, as from the gums, teeth, nose and the lungs. Yet organic hemorrhages are more abundant, and the blood is either red or black, and quickly coagulates.

In treatment one may use hydrotherapy, either hot or cold applications to the epigastrium, and also suggestion, especially medicamentous suggestion.—*La Settimana Medica*, No. 17, 1895. [Prof. Osler (*ibid.*) speaks of this as a haemoptysis, and one which may greatly deceive one and lead to a diagnosis of pulmonary disorders. Wagner describes the sputum as a pale red fluid, not bright red in color, as in ordinary haemoptysis, and which on settling presents a brownish-red sediment. It contains particles of food, pavement epithelium, red corpuscles, and micrococci, but no cylindrical nor ciliated epithelium. He states that it probably comes from the mouth or pharynx.—Eds.]

**ANGINA PECTORIS, PSEUDO-ANGINA PECTORIS OF DIFFERENT ORIGINS; THEIR DIFFERENTIAL DIAGNOSIS.**—Dr. F. de Ranse divides angina pectoris into a variety of states, of which the true angina pectoris, or angina major, is the typical form, and a number of similar or apparently similar conditions of varying origin resembling it.

He presents as typical the case of a man of sixty, who, gouty and arterio-sclerotic, had reached an advanced stage of the disease, so that a slight effort would bring on an attack ; he had difficulty in going up stairs or any little elevation. He took short walks along an even stretch of ground, and under the use of warm baths gradually improved. [Osler (*ibid.*) points out the importance of examining the vascular system, and above all in the minor grades of the disease where pseudo forms of the affection may simulate. The signs of arterio sclerosis are generally present. There are many degrees of angina. A man may only have slight precordial pain, a sense of distress and uneasiness, and radiation of the pain to the arm and neck. Such attacks may follow slight indiscretion in diet, or a disturbing emotion may alternate with attacks of much greater severity, or they may occur in connection with a pulse of increased tension and sign of general arterio-sclerosis. In a case presenting precordial pain in seizures or pains in the cervical or brachial plexus, if the aortic second sound is clear, not ringing, the pulse tension low, and the peripheral arteries soft, the diagnosis of true angina should not be made.—Eds.]

**Pseudo-Angina of Nervous or Neuropathic Origin**—Hysterical pseudo-angina.—Two varieties have been noted by the writer. One that of the vasmotor form of Eulenburg, where the attack was preceded by chilliness, paleness, a cyanotic appearance of the extremities, and associated with a sense of numbness and paresis of motion. In the second variety the attacks commence with neuralgic pains in different localities, especially in the intercostal region. In his patients the seizures appeared during the night without seeming cause except, possibly, emotion or their will being crossed. In such cases the stigmata of hysteria will be found present. [Osler states the hysterical form to be a common affection in women, though it may also occur in neurasthenic men. Vaso-motor phenomena are to be noticed : great coolness of the hands or feet, or a general feeling of deadness or stiffness, often with pain in the back of the head or neck. The attacks occur frequently, and sometimes become worse at each monthly period. Worry and disturbing emotions may at any time precipitate an attack.—Eds.]

**Pseudo-Angina of Neurasthenic Origin.**—This variety resembles the hysterical form. The associated symptoms and previous history of neurasthenia, with absence of any cardiac or aortic lesion, will exclude it.

**Pseudo-Angina Associated with Basedow's Disease.**—A pseudo-angino state may

complicate Basedow's disease. [One should seek for the characteristic symptoms of the ataxic affection : goitre, tremor of the hands, exophthalmos, tachycardia, etc., in the past and present history.—Eds.]

*Pseudo-Angina from Tabes Dorsalis*—Attacks of apparent angina pectoris may be associated with tabes, constituting a form of visceral crisis. The attacks may appear in the preataxic stage.

*Pseudo-Angina of Reflex Gastric Origin*.—Gastralgic pains may be the point of departure of actual anginose attacks, or they may set in from flatulent dyspepsia and terminate by eructations.

Pseudo-angina has been noted as following brachial or thoraco-brachial neuralgia, as well as a neuroma of the arm occurring after amputation.

*Pseudo-Angina of Neuro-Arthritis or Arthritic Origin*.—The former condition greatly resembles the neurasthenic form, except that it is associated with an arthritic as well as a neurasthenic base.

He has observed a series of cases, with a gouty or rheumatic history, where no arterial lesions could be discovered, but where the attack resembled true angina, yet where the results of treatment were favorable. The greater number of these patients suffered from gastric disturbances or neuralgias, which might have been the point of departure of the attack.

Other varieties of pseudo-angina may be noted, associated with paludism or nicotine poisoning.—*La France Médicale*, No. 19, 1896.

**TUBERCULOUS CERVICAL GLANDS AND THEIR RELATION TO CARIOUS TEETH.**—Dr. H. Starch (Heidelberg) has examined one hundred and thirteen children with tuberculous cervical glands with reference to the relation of the disease to carious teeth as points of entrance for tubercle-bacilli. In forty-one per cent. the origin of the glandular disease could be attributed to the entrance of the germ through the decayed teeth, and in many cases it could be ascertained that tooth-ache had preceded the development of the glandular disease. Where caries of several teeth was present, often a whole conglomerate of swollen glands was to be noted, while in cases where the decay was slight only a little glandular swelling was noticeable. In a number of cases tubercle-bacilli could be discovered both in the carious teeth and in the extirpated glands. In case that the glandular involvement is not the result of a systemic disease—scrofulosis—one may presume a decrease in size and a positive therapeutic effect by drawing or filling the tooth. At least an amelioration will follow. The prophylaxis of carious teeth is hence of great importance, for offering, as they do, a port of entrance for such germs as the tubercle-bacilli as well as the actino-myceses, as was demonstrated by Israel, they should be filled or drawn early.—*Wiener Medizinische Presse*, No. 18, 1896. [I have observed a case where such a causal relation seemed to be present. After drawing seven decayed teeth the patient, a girl of eleven years, picked up in health and the glands decreased in size but did not disappear.—Eds.]

**RECTAL INJECTIONS OF HOT WATER IN CHRONIC DIARRHÖA.**—Dr. Pollatschek (Carlsbad) employs with good results rectal injections of hot water frequently repeated in the treatment of chronic diarrhoea. It is not necessary to have the injection act either antisепtically nor as an evacuant, but as a sedative and a reducer of congestion, as the hot vaginal douche in gynaecological diseases. Only as much as may be comfortably retained—about three ounces—at first is to be introduced, increasing the dose later to twice that quantity. At first the temperature should be about 40° C., raising it gradually to 43° C.; as the liquid cools in passing through the syringe one should have it at about 42°–45° C. in the basin. Introduce the rectal tube high up and inject slowly; the patient should then remain quiet. Repeat the injections once or twice a day for as long as necessary. A diminution in frequency of the stools will soon become manifest and they will assume a more normal form. This treatment is of service in ulcerative processes of the large intestine as well as in chronic diarrhoea of neuropathic origin.—*La Semaine Médicale*, No. 25, 1896.

**OXALATE OF CERIUM IN THE GASTRIC CRISES OF TABES DORSALIS.**—Dr. P. A. Ostankoff recommends the oxalate of cerium in the vomiting and gastric crises of tabetics. Given in doses of 0.5–0.15, three or four times a day, it decreases the frequency of vomiting, calms the gastric pains and quiets the thirst, which is so intense during the crisis, and finally shortens greatly the duration of the attack.—*La Semaine Médicale*, No. 31, 1896.

## GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D., AND H. L. NORTHRUP, M.D.

**SURGICAL HINTS.**—When a patient comes to you complaining of symptoms in or about the rectum, it is best not to give a final opinion until you have examined the empty bowel. If necessary, require him to take an enema, and then return for further examination.

Never give an opinion based on appearances at the anus alone, but always explore with the well-lubricated finger as high as you can reach, and also by conjoined touch with a finger of one hand in the rectum, the fingers of the other hand being on the abdomen. A man may have hemorrhoids or anal fissure and also a cancer or polypus high in the gut.

There is seldom any use in treating a fractured hip in an old and feeble person. It is the patient and not his disease which requires careful watching and nursing. Get him out of bed as soon as the local shock with the accompanying swelling and pain subside, and do not invite pneumonia, bedsores, and a host of complications, by confinement in one position. Above all, if any fixation apparatus be used, let it be as light and portable as possible, remembering that in the vast majority of cases good results will be as likely to follow treatment without splint or other appliance.

Fractures of the arm and forearm are often kept too long in splints, and the resulting atrophy from disuse may, in the end, be far more serious to the patient than a moderate degree of deformity with a sturdy and useful member.

A dislocation should be reduced as soon as possible, while a fracture may often be allowed to wait for a convenient time and place, the emergency dressing simply guarding against such accidents as perforation of the skin by subcutaneous fragments of bone, dangerous pressure upon important structures, or threatened laceration of nerves or vessels.—*International Journal of Surgery.*

**THE LOCAL USE OF HYDROCHLORIC ACID IN BONE NECROSIS OF TUBERCULOUS ORIGIN.**—Waterman has ascertained by experiment that the action of the acid on healthy bone is limited to the decomposition of the mineral constituents, consisting principally of phosphates and carbonates of calcium, together with small quantities of the alkaline salts; so far as we know, not affecting the animal matter. Since in necrosed bone we have only these mineral salts remaining, the chemical action of the acid is more particularly confined to the diseased part, dissolving it without exerting any destructive influence on the underlying tissues. In this fact lies one of the real merits of the treatment; for, the diseased tissue being removed, the process of reparation can go on unobstructed.

As to the method of employment: The acid should be used in the concentrated form, whereas heretofore for the most part dilute solutions and solutions in combination with various substances have been used by other writers. The number of minims injected in each individual case depends, of course, on the amount of bone which is diseased and on the general condition of the patient. It is preferable not to use the acid more than twice a week, owing to the reaction and pain which might result. However, contrary to expectation, but little pain is experienced, and this is attributed in part to the fact that the patients are accustomed to more or less manipulation, having been dressed frequently for several months, as a rule, and also to the anaesthetic effect of the acid. In case it should produce undue discomfort, it is advisable to spray the tissues with a four per cent. solution of cocaine or cocaine and morphine a few minutes before injecting the acid; or, as an admirable substitute the chloride-of-ethyl spray. Thoroughly wash out the sinus with sterilized water in order to remove any pus or detritus, and thus permit the acid to penetrate all of the diseased bony tissue.

The ordinary sterilized glass pipette is found to be the most practical means for the application of the acid. The tube is introduced to the bottom of the sinus and the contents deposited directly upon the necrosed structure. After this, allow a minute to elapse, then irrigate the sinus with a saturated solution of bicarbonate of sodium, and apply a wet myrrh dressing. The object in using the latter in preference to dry dressings is because of the marked fetor noticed in many instances after the first two or three injections.

The conclusions drawn from the cases reported are as follows:

1. No evil effects have resulted from its use.
2. The use of the acid in its concentrated form is preferable.
3. When the area of necrosis is extensive, operative methods are advised.
4. Its action is limited to the necrosed area; whereas curetting may remove both diseased and healthy bone.
5. By the disintegration of the dead bone the newly-formed tissue has a better opportunity for its more rapid development.—*New York Medical Journal*.

**REPORT OF A CASE OF REINFECTION OF SYPHILIS.**—In consideration of the fact that there are so few authentic cases of reinfection of syphilis on record, and that so many of the great syphiliographers of this country and abroad say in their writings that they have never seen such a case, Collings feels justified in placing this one on record.

The patient, Fred C., aged 28 years, single, a miner by occupation, came to him a year ago and gave a history then of having had a chancre eight years previous, followed by secondary manifestations. The resultant scar of the chancre is located on the dorsal surface of the penis to the right of the median line, and about one-half inch from the corona glandis. The patient was a very intelligent man, and gave a perfectly clear history. The chancre appeared 21 days after intercourse, and this in turn was followed by a roseolar rash over the body, alopecia and mucous patches in the mouth and throat. In all, his treatment extended over two years, during which time he made two trips to Hot Springs, Ark., taking a thorough mercurial course, in conjunction with the baths and under the direction of competent physicians. During the first eighteen months of the disease he had mucous patches in his mouth and throat a good part of the time.

After the lapse of two years from the appearance of the chancre he went west to the Pacific slope, and for six years remained absolutely free from any syphilitic manifestation. When Collings saw him a year ago he had some rheumatic pains, which were thought to be due to his occupation—mining. There was then no evidence of syphilis whatever.

Recently he presented himself with the following history: Nearly nine years after the first chancre and 8 days after exposure, there appeared a chancre on the dorsal surface of the penis one-half inch from the corona, to the left of the median line, the scar of which can be plainly seen and felt now. Six weeks from the appearance of the sore mucous patches developed about the anus, to which he applied various salves without relief. Two weeks later, or about two months after the appearance of the chancre, an eruption appeared on the scalp. These spots were as large as a one-cent piece and moist. At the end of the tenth week a mucous patch developed on the under surface of the tongue to the left of the frenum. This has disappeared under treatment, but there is now one plainly seen on the tip of the tongue. Toward the close of the thirteenth week there developed two spots on the left calf and one over the right gluteal region. These were as large as a silver twenty-five-cent piece, dark, excoriated, and moist and, while they are now healed perfectly, they are still considerably pigmented.

At the beginning of the seventeenth week of the disease, the epitrochlear glands, the suboccipital, and those in the inguinal region were markedly enlarged.

This Collings believes to be a true case of reinfection of syphilis.—*Journal of Cutaneous and Genito-urinary Diseases*.

#### GYNAECOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D.

**FORCEPS ON THE AFTER-COMING HEAD** (Oehlschlaeger).—Schroder taught that forceps should not be applied on the after coming head, but that they should be replaced always by pressure on the head from above and manual extraction below. Oehlschlaeger reports a case where the above treatment was tried, but

delivery could not be accomplished without considerable force. He then applied the forceps and delivered the child. The infant respired feebly, and died in fifteen minutes, in spite of every effort at resuscitation. He believed the centre of respiration had been injured previous to the application of the forceps by traction on the child's neck. He believes that if the head cannot be delivered by moderate traction the forceps should be applied at once. The application of the forceps on the after-coming head is often difficult for the beginner and inexperienced physician, particularly in narrow pelvis, and requires special care not to injure the soft parts of mother or child.—*Centralblatt für Gynäkologie*, No. 31, 1896.

**THE PATHOLOGY OF PROLAPSUS UTERI.**—Winter has made a careful examination of the subject with reference to hypertrophy of the cervix. He is of the opinion that prolapse of the vaginal walls will not drag the uterus lower than the introitus, but that complete procidentia and elongation of the cervix will be produced only by the pressure of a cystocele filled with urine. In rare cases a large rectocele may push out the posterior wall of the cervix in a similar manner. Hypertrophy of the cervix does not depend on the traction of the vaginal wall.

Mackenrodt does not believe that relaxation of the peritoneum plays a rôle in causing prolapsus, but rather it is produced by relaxed uterine ligaments of the uterus or vaginal bands, especially the vesico-recto-vaginal septum, relaxation of the tissues of the vagina or uterus, or a combination of both. Elongation of the neck of the uterus is a symptom of primary prolapse of the vagina, and always requires amputation to obtain permanent relief.

Olshausen expressed an opinion that relaxation of the ligaments and fascia causes the primary prolapsus, and that a relaxed peritoneum is only a passive agent. Primary anterior descent of the vagina often begins in pregnancy labor, almost always with the first labor. The cystocele is secondary. If it once occurs it leads to prolapsus. The traction of a cystocele will draw out the cervix. Rectocele has little influence in causing prolapse of the posterior vaginal wall.

Martin emphasized the fact that inflammatory processes are often important agents in the etiology of procidentia. Puerperal processes and injuries of the fascia lead to diverticula formations of the bladder and bulging of the vagina, aided by abdominal pressure from above. Masturbation is an important cause of prolapsus. He recommends amputation of the cervix and vaginal fixation. Careful colporrhaphia will not always cure prolapsus.

Czempin considers the condition of the pelvic floor important in reference to secondary prolapse. The levator ani, pelvic connective tissue and pelvic fascia support the bladder, uterus and rectum. A primary prolapse, in a nullipara, of the bladder and vagina is improbable, without primary prolapse of the uterus from congenital relaxation of the uterus and its ligaments. In such cases, with a high degree of relaxation of the pelvic floor, it will be necessary to extirpate the uterus to cure the patient. Gottschalk called attention to the importance of a general enteroptosis as an etiological factor, and the frequent complication of pendulous abdomen, floating kidney, and hernia. He includes in this a high degree of relaxation of the abdominal walls, of the pelvic floor and of the entire peritoneum, not merely the pelvic peritoneum, with, at the same time disappearance of the panniculus adiposus, and general malnutrition. Women who have had many pregnancies furnish the largest contingent of these cases.—“Transactions of the Obstetrical and Gynaecological Society of Berlin.” *Centralblatt für Gynäkologie*, No. 31, 1893.

## OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

**WHAT SHALL A GENERAL PRACTITIONER DO FOR AN ACUTE OTITIS?**—Dr. Dench, in the *Archives of Pediatrics*, says that if a patient suffering from inflammation either of the external auditory meatus or the middle ear is seen in the

early stages of the attack, the physician should attempt to abort the inflammation as well as to relieve the symptoms. He vigorously condemns the old practice of dropping warm sweet oil or the mixture of sweet oil and laudanum into the external auditory canal for the relief of "earache," and says such a practice is a relic of barbarism which deserves no place in modern medicine. As abortive treatment, local abstraction of blood by wet cupping or the use of natural leeches is recommended. The wet cupping or leeches should be applied immediately in front of the tragus, and from one-half to one and one-half ounces of blood may be withdrawn. The patient should be kept in bed, and a free catharsis instituted. It is frequently wise to follow the abstraction of blood by the administration of an opiate sufficiently powerful to quiet the patient for five or six hours. In all cases heat is a most valuable means for the relief of pain, dry heat being preferable. A convenient method of applying dry heat is found in the use of small hot salt-bags, which may be introduced into the meatus, heat being applied externally by means of the hot water bag and other devices. These salt-bags are conveniently made by cutting off the finger-tips of a small kid glove, filling them with salt, and placing them upon a hot plate until they are completely heated, after which they are placed just within the meatus. The author does not favor the use of moist heat in any form during the early stages of the acute otitis, because of the fact that by its use the tissues are softened and disintegration encouraged. If the inflammation is not aborted and discharge makes its appearance, frequent irrigation of the external meatus by means of a weak antiseptic solution (bichloride of mercury 1:500 or boric acid) is the best means for combatting the inflammatory process and for preventing its extension to the neighboring parts. It is unwise to stop the meatus with cotton or to keep the ear covered, as in this way local infection of the canal is liable to occur, causing circumscribed or diffused inflammation. Under no condition should any attempt be made to diminish the quantity of discharges until the temperature becomes normal and all pain has disappeared. In the majority of cases careful cleansing is the only treatment required, the discharge ceasing spontaneously. Astringents are not recommended, and in cases where the discharge persists the author simply advises the use of a solution of boric acid in alcohol as an instillation after syringing. The objection to solution of sulphate of zinc and other kindred instillations is that they form a splendid nidus for vegetable parasites.—*Therapeutic Gazette*, May 15, 1896.

**OPERATING IN CHRONIC GLAUCOMA.**—In a discussion on this subject before the section of Ophthalmology of the British Medical Association, Mr. Priestly Smith presented the following conclusions as the result of his personal experience :

1. It is right to operate at any stage of the disease, so long as there is any sight worth saving, provided that the patient's general condition does not forbid an operation, and that he or his friends have been given clearly to understand that the operation is the only means, but not a certain means, of avoiding blindness.

2. The immediate safety of the eye, as regards the operation, depends chiefly on the avoidance of injury or displacement of the lens and deep-seated haemorrhage. The making of a scleral puncture, so as to slacken the eye, immediately before the iridectomy, is a valuable safeguard against injury of the lens during operation, and displacement of it afterward. Scrupulous attention to the condition of the patient as regards sleep, bodily tranquillity and the action of bowels and kidneys, are the chief safeguards against deep-seated haemorrhage, but in certain cases this complication is inevitable.

3. The ultimate success of the operation depends largely on the formation of a permanent subconjunctival fistula which keeps the eye slack. The presence of such a fistula is shown by a bleb-like elevation of the conjunctiva over some part of the cicatrix. Iridectomy for glaucoma will be a more perfect operation than it is at present when we have learned how to establish such a filtration scar in every case.

4. Permanent retention of vision is not always secured, however, by an operation which fulfils the requirements already mentioned. The optic nerve, like other nerves, when once it has been reduced to a condition of partial atrophy, as in advanced glaucoma, is especially liable to undergo further atrophy when the nutrition of the nervous system in general fails. Anxiety, overwork, loss of appetite, and loss of sleep are potent causes of such failure.

The treatment of glaucoma must, therefore, include, in addition to an efficient operation, careful and persistent attention to the health and habits of the patient.—*The Journal of Ophthalmology, Otology and Laryngology*.

## MONTHLY RETROSPECT OF HOMOEOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D.,  
FRANK H. PRITCHARD, M.D., AND F. MORTIMER LAWRENCE, M.D.

**PLATINA IN IRRESISTIBLE IMPULSE TO KILL.**—Dr. Gaudy relates the case of a woman of about 35 years who demanded to be relieved of a peculiar and seemingly irresistible impulse, namely, to kill her husband whom she loved passionately. Their married life was happy and there was not the least cause of dissension, while her husband had not given her any cause to suspect his fidelity. The sight of a knife or of any metallic instrument exercised an irresistible attraction over her, and often she was obliged to leave the table in order not to yield to this unfortunate decision. He learned that a few months before she had lost a child a short time after confinement. This had been followed by profuse and desperately persistent uterine hemorrhage. Recovering from this, she became restless, irritable and her whole existence was ruled by this sorrowful impulse. He prescribed platina 6x and 30x, and in a short time she became mentally quieter, so that she revealed the obsession to her husband. Seemingly the symptom did not recur. He gave the remedy on account of its recommendation by Jahr, who prescribed it to a woman with a desire to kill her child.—*Journal Belge d'Homœopathie*, Vol. II., No. 8.

**KALMIA LATIFOLIA IN HEART DISEASES.**—At a recent meeting of the Leipsic Homœopathic Union several cases were reported where kalmia latifolia had been given with good results in various heart affections, where allopathy and spig. as well as naja trip. had been employed without success. The characteristic conditions are: Rheumatic and erratic pains, which threaten to affect the heart; remittent, gastric and nervous fevers; eczematous eruptions; syphilitic heart diseases; skin, heart complications of rheumatic and gouty processes; cardiac hypertrophy; thickening of the valves of the heart; the pulse and heart-beat increase in frequency.—*Leipziger Populare Zeitschr. f. Homœopathie*, 1896.

[Dr. A. Clinton, *Homœopathische Monatsblätter*, No. 12, 1895, regards kalmia as an important remedy in articular rheumatism, especially where the disease jumps from one point to the other, beginning in the upper and going into the lower extremities. The articulation is swollen, red and hot, while the pains are aggravated by the slightest movement and at the approach of night, or on becoming warm in bed. It seems indicated where the rheumatism has followed sudden exposure to cold, or a cold wind without any predisposition to the disease being present. In these cases there is but little fever, external heat or sweating, while the pulse is but little accelerated; indeed, in some cases slightly slowed. Also in cases where the disease threatens to undergo metastasis to the heart, with shooting and lancinating pains through to the shoulder blade, with palpitation and an anxious expression of the patient's face, a rapid or weak pulse and dyspnoea, he has found the remedy of service. In organic heart diseases, for example, in hypertrophy with dilatation, he has seen in two cases a decided improvement, as well as in one case of fatty degeneration of the heart-muscles, with seizures of angina pectoris, associated with a slow and weak pulse, eructation of gas and disturbance of respiration. This remedy relieved after all others had failed.

The cases of neuralgia where kalmia was curative were those of great violence, but without any other signs of disturbed health beyond debility. The pains were chiefly the results of taking cold and would appear irregularly without any definite duration, frequently suddenly, but usually irregularly, and their disappear-

ance was similar. They were increased by mental or bodily exhaustion, overexertion and were ameliorated by eating. They were most often seated on the right side of the face, and would extend into the right arm, with a subsequent feeling of that part having gone to sleep. The pains themselves were stitching, piercing, tearing or pressing and shooting from within outwards, and often accompanied by vertigo and a reddened face. He has also cured a violent neuralgia of the right arm with this remedy. The lady had already suffered from it over a month. It proceeded from the neck, which was sensitive to touch, and extended from along the arm into the little finger and the ring finger of the right hand. The pain would appear paroxysmally, and was worse before midnight. She had a strikingly slow pulse of 45 beats in the minute, which had been thus for years. *Kalmia* 3x was given every four hours; in a short time she felt relieved, and in 4½ hours she was cured. The remedy was continued for several weeks in the sixth decimal dil., when her pulse-rate rose to 68 and she felt completely well. No history of rheumatism could be discovered. He has no faith in its action in left-sided pains. The third is the preparation he generally uses.—[Eds.]

**SPIGELIA IN RHEUMATISM.**—Dr. Mackenzie reports the case of a woman, aged 57, whom he attended during one winter for cough and bronchorrhœa, which improved under *ant.*, *tart.* and *rumer.* Four months later she had a severe attack of vertigo, with *muscae volitantes* and loss of appetite, after eating sprats. This passed off under *pulsilla* 12. She remained well for two years, then returned with the following symptoms:

Pains in the head, nose and eyes, darting and aching; they are worse at night and in damp weather. There is vertigo on stooping, and heat of head. There are similar pains about the heart, its action is slow and irregular, but there is no murmur. Also sudden pains attack her at the bottom of the back. There are no gastric or other symptoms.

Ordered *spigelia* 3x. In a week the pains were much better. Repeated *spigelia*. This speedily cured, and the patient did not return.—*Monthly Hom. Review*, July 1, 1896.

**PLANTAGO IN ACUTE AURAL CATARRH.**—Dr. Ord records the case of a man, aged about 35, who has five or six times in the last few winters had most violent and distressing earache, lasting two or three days, and followed by perforation of drumhead and discharge of sanguineous serum, with relief to pain and transient deafness. The pain was throbbing, and completely incapacitated him from business. All kinds of old-school treatment had been tried, but nothing relieved it except five-grain doses of exalpine, which the patient freely used with port wine. During an attack the drum was seen to be bulging, red, and to visibly pulsate. There is always some chronic catarrh always going on in his ears, but hearing is very slightly affected. The attacks are brought on by exposure, mental over-exertion or want of sleep. Last winter two threatened attacks were stopped by *plantago* 6, three drops every hour. When first prescribed pain had lasted six hours and was rapidly increasing. *Belladonna* relieved the violent throbbing, but did not affect pain, which, however, disappeared after three doses of *plantago*. Patient had a good night, and went about his work as usual next day, complaining only of fulness and soreness of the ear, which had gone the second day. A second attack was similarly aborted about a month later. A year after the patient had remained free from attacks.—*Monthly Hom. Review*, June, 1896.

**CALCAREA IOD. IN RACHITIS.**—Dr. Mackenzie notes the case of a boy, st. 3, who had never attempted to walk, and was unable to stand or even raise himself up. It was a well-marked case of rickets, all of the usual symptoms being present. He was lively and cheerful, and had a good appetite: bowels confined. Ordered *calc. iod.* 3x, gr. iij. t. d. s. In a fortnight there was decided improvement the child making attempts to get up. One month from commencing *calc. iod.* a tooth was cut. A fortnight later voluntary attempts to stand and walk were made. *Silica* was now tried for a fortnight, but though progress was continued, *calc. iod.* seemed to suit best, and was returned to. Four months after commencing medicine the fontanelles were closed, and the child could stand. In another month he walked well, the symptoms were all greatly diminished, the child vigorous and strong. Treatment was somewhat hampered by ascarides, which were disposed of by *tenarium*. Convulsions were caused by them once, but yielded to *belladonna*. Altogether, *calcarea iod.* was given for five months.—*Monthly Hom. Review*, July 1, 1896.

**ARNICA FOR A TRAUMATIC TUMOR OF THE NECK.**—Dr. Bryce tells how nine months after a severe fall and bruise of the neck, over the posterior cervical spines, a tumor formed, having the following characteristics: It was firm and rather hard, there was no fluctuation, it was slightly movable and evidently not fixed to the bone, but probably in the deep cervical fascia. In size it became as large as a closed fist. *Arnica 2x* was ordered internally, and without local treatment removed all trace of the swelling in a month.—*Monthly Hom. Rev.*, June 1, 1896.

**LYCOPodium IN CHRONIC ABDOMINAL PAINS.**—According to Dr. Ord, a shoemaker, at 58, had for several years suffered from attacks of severe pains shooting through bowels into privates. They were especially worse in cold weather, were generally felt when sitting and were so severe as to double him up and prevent his walking. Formerly they would cease at night, but now they would continue for two hours after he went to rest. The pain ceased usually when he lay down, but returned immediately on sitting up. It was worst at the bottom of the bowels, and shoots into the scrotum, and sometimes would be relieved by holding up the latter. Finally the attacks became so severe that nothing would hold them. The patient suffered much from fulness after food, and was afraid to eat. There was much flatulence in bowels, which were constipated. His urine was thick and deposited a red sediment. Examination failed to detect any cause of trouble or tenderness, though there was distention from flatus. The ethereal tincture of *lycopodium* was ordered, two drops of the *2x t. d. s.* before food. In a fortnight the patient returned in delight, having suffered no pain after the second day and believing himself cured. Six months afterwards he remained well.—*Monthly Hom. Review*, June 1, 1896.

**PLUMBUM MET. IN CHRONIC CONSTIPATION.**—Dr. Ord, of Bournemouth, reports the case of a young woman, aged 22 years, who had suffered from chronic constipation for four years, obtaining relief only by pills or purgatives, without which she would go from seven to fourteen days having no motion. Patient was becoming thin and anaemic, and suffering from constant colicky pains before food, which were much worse before the periods. Menstruation had been too frequent, but was now regular and normal. Appetite fair, tongue clean. After *sax* and *hydrastis* had failed, *plumbum met. 3x* was ordered. In three days a natural motion occurred, and after this the bowels moved regularly every second day and continued to do so for a year afterwards.—*Monthly Hom. Review*, June 1, 1896.

**PULSATILLA IN CHRONIC LARYNGEAL COUGH.**—Dr. Bryce, of Edinburgh, reports the case of a nurse who complained of a hard distressing cough which had troubled her on and off for eighteen years. Examination by a skilled laryngoscopist revealed nothing but slight congestion of the vocal cords. *Spongia* and afterwards *causticum* were prescribed, but failed to relieve, though the larynx was evidently the seat of the trouble. Afterwards it was learned that the cough commenced originally after measles in childhood, and since it was always worse in a hot room and relieved by going into colder air, *pulsatilla 30* was prescribed. After a few days the cough ceased and has never returned.—*Monthly Hom. Review*, June 1, 1896.

**RANUNCULUS BULBOSUS IN PLEURODYNIA.**—Dr. Ord records the case of a Mrs. W., at 45, who felt a slight pain in the left side which caught her breath, but soon passed. Two days later, on returning at night from a concert, the pain reappeared, becoming rapidly worse. He found the patient in bed; respiration rapid, shallow, and catchy; she could not move or draw a breath without jumping up in bed from pain. There was tenderness around left (5th, 6th, and 7th) ribs; no cough, no pleuritic rub, no dulness on percussion; no cardiac murmur. Temperature, 99.3°. Patient very restless and distressed. He ordered a poultice to the side, and *aconite* and *bryonia* internally; Next day a little easier, but very bad. Temperature, 97.8°. *Aconite* stopped, and *cimicifuga* given in alternation with *bryonia*. Two days after, pain very little better; feels well in herself, but cannot move or breathe in comfort; pain worst on raising arm and sneezing; still violent and tearing. Side was now strapped and *sulphur* tried, but with very little benefit. Pain had now settled in a spot the size of a crown piece over apex of heart, which was very tender to the touch. Ordered *ranunculus bulbosus 1x*, gtt. v. every two hours. In two days the pain was gone, and she was up and doing her work. In that week there was slight soreness on sneezing, or raising the arm only. Next week she was well, and two months later no pain had since been felt.—*Monthly Hom. Review*, June 1, 1895.





PROF. CHARLES G. RAUE, M.D.

BORN MAY 11TH 1820.

DIED AUGUST 21ST, 1896.

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## CAN THE LAW OF SIMILARS BE PROVED?

BY M. W. VAN DENBURG, A.M., M.D., FORT EDWARD, N. Y.

### PART I.

*Mr. President, Ladies and Gentlemen, Members of the American Institute of Homœopathy:*

To me has been assigned the task of presenting to you "An Experimental Demonstration of the Law of Similars," with the appended problem, "Can its Existence and Operation be Proved?"

If, in this discussion, I produce sufficient and reliable evidence of the operation of a *law of cure by similars*, then there can be no question of its *existence*. Hence, my whole effort will be directed toward a demonstration of the fact that such a law is in constant operation in the care of the sick.

The recognition of *law, in the abstract*, is a matter of slow growth in the development of the human race.

The lowest savages are on a plane only slightly, if at all, above the social brutes in this respect. With them, in most cases, might is right, and might is law, in so far as social laws relating to persons are concerned; the next step higher, a respect for the law of possession, or property, is only found in animals

of advanced intelligence, and then only respected when backed by might.

But the recognition of a *General Law in nature* is an outgrowth of the most advanced civilization the world has yet attained.

The child-like savage mind places a separate intelligence behind each class of phenomena, and peoples the earth, the air and the water with divinities, each of whom has his special task to perform. All things are ordered by the will of the presiding divinity.

In a higher civilization all this power is concentrated in One Being, and He it is who orders the phenomena of the universe, or He may have a co-worker, a Satan, in a subordinate but evil being, who does the evil work of creation. To the savage, a god thunders marvellously with his voice and sends forth his lightnings; it is another god's voice that causes the rivers to flow; a god breathes in the soft south wind, and another in the biting blasts of the north.

In a higher development one God does all this. He maketh the hinds to calve; He bringeth forth Mazeroth in his season; He guideth Arcturus and his sons.

When, however, His wonderful works are studied carefully, and the order of all natural phenomena is accurately observed, it is found that this order is *an invariable sequence*. The theory of personal interference is nowhere substantiated by a single authentic example. The savages's imagination of divine interference, filtered through the experience of the ages, and finally scrutinized by modern methods of research, fades into *absolute nothingness* and gives place to a constant uniformity, which is expressed in the phrase, like causes always produce like effects.

Given all the causes and all the effects of any particular class of phenomena, *and the order of their occurrence*, the modern mind finds it unthinkable that these causes, in the same relationship as before, should not produce results of precisely the same character as in the former instance. So thoroughly has this been enforced in every realm of research, in every avenue of thought, and by every careful observation, that a single well-established exception to this law would startle the scientific world, and demolish our conceptions of the stability of the universe. It is not only the law of stability, but it is also the law of necessity.

Even if God were to interfere to change the order of events, it would not, and it could not, take that order out of the realm of *Natural Law*. For a new element introduced among previously existing causes, demands a new result; it is impossible that it should be otherwise. If the result be the same, proof must be shown of a new cause, if the result be different, all experience demands an additional cause. And this is *Natural Law*.

With this inexorable fact before us, there is but one conclusion possible in matters therapeutic, and that is that all the phenomena manifested in curing disease, if there be any such thing as curing disease, takes place according to *Natural Law*.

The reproach of the medical science to-day is, that no such law is recognized by the majority of the medical profession. It is impossible, it is unthinkable, that such a law does not exist. If drugs have in a single instance promoted, or produced a cure, that cure has established a fixed order of sequence. Given the same causes, the same effects result, and that single cure established a law of cure by the use of drugs.

But it should not be forgotten that drug cure is only one of several methods of cure. And it may be well to briefly note the several methods, that one may not be confounded with another.

There is the method of *mechanical cure*, which relieves and corrects mechanical changes of the normal physical system. It replaces dislocated joints, coapts fractured parts, strives to remedy physical defects, such as missing or deformed parts, removes foreign bodies and mechanical obstructions, abnormal growths and deleterious accumulations, *by the employment of mechanical means*.

This is true not only of knives, of splints and bandages and ligatures, but also of cathartics, emetics and other drugs given for mechanical ends.

The method or law of *hygienic cure* embraces not only suitable food, clothing, air, water, light and temperature, suitable dwellings, occupations and recreation, but proper ethical and social influences; also the removal of all deleterious influences of a poisonous, hurtful or debasing nature. In a word, it strives to make the environment harmonious with the physical, social, mental and moral demands of the human being. Chemistry, microscopy, physics, biology, physiology and psychology, inves-

tigated by means of the most carefully conducted scientific observations, have opened a broad field of practical knowledge indispensable in curing and preventing diseases.

The discovery of many specific disease-germs, the discovery of many hitherto unsuspected avenues of infection by these germs, and the continued observations now being conducted in these directions, are all within the sphere of hygienic cure. Modern medicine points with a just pride to these victories, these practical results of scientific researches. The physician who ignores these results, or who fails to apply the precautions they demand, imperils his patient's life to an inexcusable degree. Hygienic cure is practically an indispensable coadjutant to drug-cure and surgical cure.

Still another method of cure should be noticed in passing. The method by *suggestion*, the hypnotic cure. With this may also be classed an allied method, the so-called *faith cure*. I have treated these methods at greater length elsewhere, and desire only to say here, that their therapeutic results are beyond question successful in *certain cases* and under exceptional circumstances. But the conditions of cure by these methods are too limited, and the sphere too narrow, to be of practical use to the exclusion of the other means. Psychic cures are successfully applicable to only a very limited number of patients, of peculiar, if not abnormal, mental development. The extreme sensitiveness, excitability, docility and impersonability required in the patient is found only in a very limited number of cases. Ignorance, credulity, and I had almost said gullibility, are necessary elements in this method of cure. With the general spread of education, and the diffusion of scientific spirit of research, this method must become more and more restricted and finally obsolete. Do not, however, imagine that in the present it is to be dismissed with a mere mention.

Every physician has a few cases to whom the psychic method is more or less applicable. It is an excellent adjuvant to other therapeutic means, and in some cases of nervous diseases an indispensable adjuvant. The practice of this method should not be relegated to cranks and charlatans, but be made a part of the resources of every practitioner of medicine. He who neglects the mental and psychical side, ignores an important factor in the cure of many perplexing cases.

The beneficial effects of *heat* and *cold*, either moist or dry, must be acknowledged in suitable cases, also the beneficial effects of *electricity* and *magnetism* in restricted limits. The same is true of *enforced rest*, *enforced motion* and *massage*.

All questions of climate, of sanation, of antiseptis and disinfectants are hygienic measures, as has been said. Mineral waters are drugs. Lavage of the stomach, the colon, the vagina, the urethra and bladder, the nasal passages, etc., have at times beneficial results, and are partly hygienic, partly mechanical, and partly drug-effects when drugs are combined for this purpose. Even bleeding may, under certain circumstances, be demanded, as in an apoplectic seizure in a full-blooded person, when better means are not at hand.

I am inclined to think that *counter-irritation* has played a much wider rôle in the cures wrought by allopathy than has hitherto been acknowledged by us. Not only by the use of external irritants, as blisters and revulsives, but also internal irritants as well. Medicines which have been given until their toxic effects have become considerable may not in every instance have been wholly devoid of beneficial effects; and when such effects have followed the use of large doses, it may well be questioned whether the action did not fall under the head of counter-irritants.

Bungling as this method is beyond all doubt, ineffectual and even dangerous, as it is in many cases, still if it has been productive of cure in even a single instance, it is incumbent upon us as investigators to acknowledge its efficiency as well as its inefficiency. In studying the curative effect of drugs in disease, no application that is beneficial should be denied a just and fair consideration.

If we investigate the *history of drug cure*, we shall find that from time immemorial drugs have been used by the human race to cure disease.

It is even claimed that some of the lower animals in sickness resort to the use of drugs in the shape of growing plants and trees, or of minerals found on the surface of the earth, and this statement appears to have been well authenticated in some instances. Be that as it may, no known savage race is so low in the scale of intelligence, that it has not the traditional use of some drugs. They are derived from the vegetable, animal, and

mineral kingdoms, and are used to cure the sick, to remove obnoxious persons, to produce abortions, as aphrodisiacs, and to produce intoxication. Drugs are also used by savages to stimulate the powers of endurance, allay hunger and dull pains, to capture game and to destroy vicious wild animals. When, therefore, we consider how remote has been the use of drugs, medicine may justly claim to be the oldest science known to the human race, except hygiene. The latter deals with food, shelter and clothing, as well as a suitable locality for inhabiting, and is of the first necessity, even to the savage.

One important thing remains to be noted. Back of every method of cure, underlying all therapeutic discoveries of every description, must be granted *the natural tendency* of all organized life to return to the normal state of health, when for any reason there has been a departure therefrom. This is the *vis medicatrix naturæ*, without which all cures would be impossible. When this inclination of nature for any reason is destroyed, all hope of cure goes with it.

This tendency to health may be present in any given case in varying degrees. It may be so strong that health will be restored in spite of deleterious treatment; or of so weak a tendency that only the most skilful and delicate treatment will avail to save the organism from destruction. Often the only thing necessary for restoration is hygienic treatment, the removal of deleterious influences, the supply of proper food, clothing, shelter, exercise, and recreation.

Again, there are cases where *positive drug interference* is demanded if the cure is to be wrought speedily, safely and surely.

First, then, we start with the assumption that drugs may, under proper conditions, cure disease. This much is taken for granted.\*

“A drug is any substance, vegetable, animal or mineral used in compounding medicine.” This is the *Century’s* definition. We may go further and say, a drug is any substance which, from its inherent qualities is capable of altering the natural state of health, and from its natural qualities also capable of curative use in disease.

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\* The proof of this proposition devolves on the clinical discussion of drug-cure.

Too much mince-pie, or pork and beans, may cause sickness, but it is the quantity not the quality that does this. If the meat be tainted and causes sickness, it is the quality that does it; and if that quality can be isolated, it becomes a drug; if it can be rendered a stable compound, it may be used to cure disease. Hence we infer that a drug alters the state of health from the *peculiar qualities* it possesses.

Drugs are, for the most part, poisons, at least they are substances that under certain conditions are deleterious to health. Under proper conditions they are also beneficial in restoring health.

An *experimental demonstration* of the law or laws by which drug-cures are accomplished requires that—

- (a) *The results of the use of drugs* be examined;
- (b) *Their methods of action* investigated; and
- (c) *Reasonable proof of the method or methods* by which they act, be produced.

The beneficial effects of drugs being granted in some cases, *the methods of their beneficial action* may be investigated from two distinctly different standpoints.

*First.*—We may seek to learn *their physiological effects in disease*.

While this would seem the most natural method of study, it is at the same time the most impracticable. H. C. Wood characterizes this method as “beyond human prescience.”

The reasons for this conclusion are found in the multiform variations of the phenomena of disease.

No standard of uniform action can be established by this method.

The same disease has so many different forms of manifestation in different persons, and in the same person at different times, that Wood’s conclusion is perfectly justified by experience.

*Second.*—We may strive to learn what action, if any, the medicine has upon the organism in health, and then seek for some constant relation between the curative effects of the drug and its effects upon the healthy.

In this search we shall be greatly aided if we select such drugs as are known to have an established repute for curative effects, and at the same time have a more or less clearly de-

fined recorded history of "physiological effects" upon the healthy human organism. The comparison of these two sets of phenomena should discover whether there is any constant relation between the one and the other. The proof may not be positive in every case, but if there be a general trend of facts, a general uniformity of inter-relations in the phenomena on the one hand and on the other, the presumption is very strong that more careful and painstaking observations would tend to fix the limits of this relation clearly.

If it could be shown that no such investigation has ever been carefully instituted, the part of wisdom would be, to begin it at once.

If, however, it can be shown that such comparisons have been made, then it would be equally wise to examine carefully and without prejudice into the conclusions that have been reached. In such an examination it would be well to keep in mind the fact that often the most practical results are beyond the power of scientific explanation as to their ultimate nature.

Herbert Spencer well says of the ultimate limits of human knowledge, that "its advancement has been towards the establishment of both a positively known and a positively unknown." (*First Principles*, p. 127, 1864.)

Now, nothing is so positively unknown as the nature of the vital force. Still its manifestations form the basis of all physiology.

Hence, we might naturally expect to find our road completely blocked sooner or later if we pushed our research for a law of cure in the direction of the nature of the "ultimate effects of drug-action."

Spencer closely points out in the above connection, the road to be pursued in seeking for a general law of nature. He says, "Though we can never learn the (ultimate) nature of that which is manifested to us, we are daily learning more and more completely the *order of its manifestation*," and this *constant order* we call *natural law*. (*Ibid.*)

It is now a full hundred years since a German physician, well versed in the medicine of his day, proposed a standard. Samuel Hahnemann declared, in 1796, that when a drug had been thoroughly tested in all its physiological effects upon the healthy human organism, and these effects had been carefully

recorded, this record was the best standard by which to compare the curative effects of the drug upon the sick. He further declared that such a comparison will show that a dose of the drug, *too small to produce poisonous effects, will prove curative in all diseases that closely resemble the physiological sickness caused by large doses of the drug*, or doses large enough to make a healthy person sick. And, conversely, that *too large doses, that is, doses so large as to have toxic or physiological effects, will invariably prove injurious, under like circumstances, in all such cases.*

From this method of comparison, and the two deductions founded on its experimental application in numerous instances, have arisen all usages, customs and precepts regarding *small doses*, size of dose, repetition of dose and all the numerous details, observations and theories that have tended to obscure, retard and prejudice the cause of homœopathy in the eyes of the uninitiated.

That the method has been clearly recognized as a good one, by Alfred Stillé and H. C. Wood, two of the most philosophical writers on *materia medica* and *therapeutics*, that the so-called allopathic school have produced, is beyond dispute. Sidney Ringer has sedulously avoided all discussion of a standard of comparison. Roberts Bartholow is too satisfied with the superiority of his own wisdom to seek for any further enlightenment, while Herbert Emory Hare is too narrow, too prejudiced, too *ex parte*, not to say too wilful in his representation, or rather misrepresentation of facts, to be able to draw any conclusion worthy the attention of a serious-minded thinker. One of the most palpable effects of the influence of the principles announced by Hahnemann, and his two deductions above mentioned, is seen in the abolition of the custom of giving large doses. This was not only prevalent in Hahnemann's time, but it was then the sole method of treatment by drugs.

Hence, when Bartholow says: "The eras of excessive dosage and of nihilism are alike relics of the past" (Bartholow, p. 17), he makes an admission fraught with a world of meaning.

The position of allopathic medicine to-day is an anomaly. It has given up excessive or even physiological doses, and has for the most part adopted a system that would have excited scorn twenty-five years ago.

What is the reason for this? First, because it has found that large doses did not do as much good, on the whole, as they did harm; and second, because it was found that small doses did no harm, and often a great deal of good. Has allopathy changed its principles in doing this? Most assuredly. In all cases where it is now using *small doses*, it is using them in accordance with the law of similars. A small dose of a drug, by which I mean a dose *too small* to produce what allopathy calls "physiological effects" upon the healthy, will produce no effects upon the sick, unless given in diseases closely similar to those caused by larger doses of the same drug in health. Hence, in all those cases where allopathy recommends small dosing as beneficial, it is applying the drug according to its homœopathic use, and nothing else. I challenge a single example from allopathic literature to prove the contrary.

It is not sufficient to say that the drug has not been known to produce this or that sickness, unless it can be shown that all *of the effects of the physiological doses upon the healthy have been exhausted*. Until then we must object that the physiological effects of the drug *are not known*, and it is not competent to adduce such a drug as evidence in rebuttal of the principles laid down.

On the other hand, in every case where a well-authenticated and full physiological investigation of the effects of a drug upon the healthy has been made, we shall find every disease for which small doses are recommended, will be matched by a similar disease produced by the physiological effects of the drug.

In proof of this I herewith present a list of drugs, part of which are quoted in by no means an exhaustive manner, to show how the recommendations of Hahnemann are now being carried out by the recommendations of allopathic authors.

Had space allowed an exhaustive exhibit it would have tended only the more strongly to prove the truth of what I here assert.

Beginning from the list in alphabetical order, I beg a careful consideration of the trend of proof. And I invite the most laborious study of any one of the drugs introduced to disprove the position I have taken, viz., that in all cases where allopathy recommends small doses as curative, "the physiological effects" of the drug, if these are well developed, will show that large doses will cause sickness in the healthy very similar to the natural sickness which the drug is recommended to cure.

"IN WHAT PARTICULARS HAS THE PROVING OF DRUGS DEVIATED FROM THE RULES LAID DOWN BY HAHNEMANN IN THE 'ORGANON,' AND IN WHAT PARTICULARS DO HAHNEMANN'S RULES AND DIRECTIONS FOR PROVING DRUGS DIFFER FROM, OR FALL SHORT OF, THOSE REQUIRED BY THE METHODS AND PRECAUTIONS OF MODERN SCIENTIFIC RESEARCH?"

Propounded by the Committee on *Materia Medica* Conference of the American Institute of Homœopathy. Considered by Eldridge C. Price, M.D., Baltimore, Md.

It is with a feeling of hesitancy that I undertake to consider, and, as far as I am able, to answer a question fraught with such grave significance. The task requires that, without fear of favor or disfavor, a critical comparison be made between the work of drug experimentation of the followers of Hahnemann and the rules prescribed by Hahnemann for such work, and also a comparison between these Hahnemannian rules and the requirements exacted by the most critical methods of "scientific research" known at the present day. In other words, to answer the question propounded, it is necessary that, first, the work of the followers be examined as to its thoroughness, taking the rules given by the master for such work as a standard, and second, the rules themselves must be examined as to their efficiency in the light of modern scientific thought.

The proposed question may therefore be divided into two, each of which queries requiring separate consideration. First, then, "In what particulars has the provings of drugs deviated from the rules laid down by Hahnemann in the *Organon*?"

On referring to the *Organon of Homœopathic Medicine*, Dr. Hering's translation, we find a number of sections devoted to a consideration of what Hahnemann regarded as requirements necessary to the construction of a reliable drug pathogenesey. It will be necessary, however, to refer only to those which have been infringed.

Section 121 says: "Finally, if we would try the effects of the weakest substances, the experiment must be made upon persons only who are, it is true, free from disease, but who, at the same time, are possessed of delicate, irritable and sensitive constitution."

This has not been observed, as records of supposed effects of drugs, which were tested upon apparently *healthy* provers—which drug preparations were among “the weakest substances”—are found mixed together with the supposed effects obtained from *diseased* persons during the administration of these same substances. In fact, Hahnemann himself infringes this section in his *Materia Medica Pura*, and herein sets the example for irregular practices in his followers. Section 142 may be offered as Hahnemann’s excuse, but this should not excuse even the master, as there are too many possibilities for mistakes in attempting to distinguish pathogenetic drug symptoms under such circumstances, even by “masters in observation.”

Section 124 proscribes the use of more medicines than one during the time of proving. This section has frequently been ignored, as is shown in records of assumed drug effects wherein other drugs have been interpolated for annoying symptoms, and also in cases where antidotes to the drug under test have been administered and the record continued after the use of the antidote.

Section 126 denies provers “all fatiguing labor of mind and body,” but provings have frequently been made upon medical students who were at the time undergoing “fatiguing labor of mind.” Hard-worked physicians have also made some provings.

Section 131 is so rarely observed that we may regard it as a universally broken rule among provers. Its entire quotation is necessary: “If, to acquire at least some knowledge of a medicine, it is found requisite to administer to the same person, several days in succession, doses of the same, progressively increased, this may show us the various morbid changes that this substance is capable of exciting generally; but we do not learn the order of their succession, and a succeeding dose often extinguishes one or other of the symptoms produced by the preceding one, or creates in its place a contrary state. Symptoms of this kind should be noted between two parentheses, as being equivocal, until new experiments of a purer nature shall have decided whether they are to be considered as the reaction of the organism, or the alternating effects of the medicine.”

This section comes very near to the heart of the question, touching closely Hahnemann’s understanding of the necessities and requirements of pathogenetic drug experimentation, and

also involves his idea of duration of drug action even when applied to therapeutics. If this section has been infringed by experimenters, then indeed the teachings and proving rules of Hahnemann have been disregarded. That this is the case, it is only necessary to refer to our standard collections of provings, where will be found records of single doses, daily doses, hourly doses and even more frequent administrations, mixed together, in total oblivion of the Hahnemannian injunction that effects of drugs from frequently repeated doses "should be noted between two parentheses as being equivocal." No distinction between doses of varying frequency is noted, but the whole is jumbled together in one heterogenous mass, in utter disregard of Hahnemannian sense, of common sense, of scientific sense.

Section 137 says: "If the dose be excessive, there will not only be several reactions visible among the symptoms, but yet more; the primitive effects will manifest themselves in a manner so precipitate, violent and confused that it will be impossible to make any correct observation." This has been ignored in a number of proved drugs, among which *thuja* is notable. In this drug the doses taken were so large that the alcohol imbibed must have commingled its effects with those of the drug.

Sections 124 to 127 are stated in Section 138 to be "necessary to the trial of a pure experiment;" but as we have seen that Sections 124 and 126 have not been obeyed—nor has Section 127, in relation to sex, always been observed—consequently, the proving of drugs in the past is shown to have deviated from the rules laid down by Hahnemann, even if we considered no further infractions.

Again, Section 139 has not been observed by the average prover. Few drug experiments have been conducted with the care in recording symptoms herein enjoined.

In Section 142 we are told that the observation of symptoms of drugs which appear in diseased conditions (pathogenetic symptoms due to the drug independently of the disease) should "be left to masters in observations;" but we find in our alleged pathogenetic symptomatologies records of symptoms supposed to have been produced by drugs during the treatment of patients for diseased conditions, and which records have been made by those we would hesitate to call "masters in observa-

tion." In the work of compiling records of mixed drug effects reported in our literature, how many such superior minds are detectable?

From the sections of the *Organon* to which reference has been made, it is evident that Hahnemann intended that drug experiments should be conducted in accordance with definite rules; but from the infringements noted it is equally evident that this intention of the master has not been observed by his followers, either in accordance with the letter or the spirit. On the contrary, our records of experiments with drugs show a most censurable lack of system, which evidences either an ignorance of the *Organon* or contempt for the wisdom of its author, or both. Assuming, however, that this irregularity, which has characterized the drug experiments of the homœopathic profession, is due to neither an ignorance of the book nor disrespect for its author, it becomes obvious that our experimenters were ignorant of the fallibility of human testimony; understanding nothing of the possibilities of collusion, self-deception, auto-hypnotism, etc.; knowing nothing—or showing no knowledge—of practical psychology, which is necessary to the management of a systematic test of drugs upon the human organism. However, until comparatively recently a knowledge of subjective influences was almost a sealed book, and even yet a knowledge of psychology in its application to material problems is in its infancy; and hence, our drug experimenters of the past cannot fairly be held responsible for mistakes which were not due to individual ignorance alone, but to universal ignorance. Accountability is proportioned to knowledge, and consequently we can hold our pathogenetic experimenters responsible only for neglecting the duty which was plainly theirs, *i.e.*, they may be held accountable for not observing the rules prescribed by him whom they recognized as master of the art of drug experimentation. (I am speaking of the work of our drug pathogenetic experimenters as a whole, and not of the work of any individual, however closely the individual exceptions may have observed Hahnemann's rules; it is the mass I am considering.)

At this juncture we are confronted with a doubt as to whether or not the rules laid down by Hahnemann were sufficiently rigid for the purposes intended; whether, at the present stage

of human history, we have not grown beyond the limitations of even the most progressive doctor of medicine of the early part of this century. To answer this doubt, we will proceed to consider the second part of the question before us:

"In what particulars do Hahnemann's rules and directions for proving drugs differ from, or fall short of, those required by the methods and precautions of modern scientific research?"

Hahnemann was not only abreast of the knowledge of the time when his work was done, but he was in advance in many respects. However, as no one denies that since the *Organon* was written, much progress has been made in all branches of knowledge, so likewise no one will deny it was impossible that Hahnemann should or could foresee all the future development of methods and of details for the more ready and more thorough demonstration of the principle of which he was the formulator. Consequently, when we regard Hahnemann's rules for proving drugs we discover them to be inadequate to the purposes of modern experimentation, which latter methods bring to bear an amount of psychological and other special knowledge, of which the wisest men in the time of Hahnemann were ignorant.

Aside from the fact that Hahnemann's rules for proving drugs are not sufficiently rigid to conform to the requirements of modern methods of thought, I think we can fairly claim that they are not always practicable. This latter is sustained by a comparison of the two sections, 108 and 121, respectively (in which *healthy* individuals are stipulated as necessary for proving drugs), in the face of a demonstrable fact that a *healthy* human being is rare, the *approximately healthy* individual representing far more correctly the race of men now inhabiting the face of the earth, just as was also the case when Hahnemann wrote the *Organon*.

In a general way Hahnemann's rules are not sufficiently definite and stringent in the directions for preliminary health records, nor do they take cognizance of the necessity for the examination of provers' objective and subjective manifestations by specialists, simply because in Hahnemann's day expert specialists, such as we now have, did not exist. This last fact alone shows the rules in the *Organon* to be far behind the require-

ments, nay, the necessities of science, and if no other reason existed, this defect furnishes sufficient cause for the formulation of new and better rules for testing drugs. There are, however, other important defects, an example of which is furnished in Section 138. In my opinion this section has caused the addition to our *materia medica* of much adventitious material. Substantially, this rule states that *all* symptoms appearing in a prover during a drug test, even though such symptoms may have appeared before the test (a "long time" before are the words, but *how long* is not stated, which is most unsatisfactorily indefinite), are the result of the drug under test. The inference may also be fairly drawn from this section, that other influences need not be seriously considered as possible causes of symptoms during a drug proving, because it is assumed that the "entire organism" is under the "sway" of "a powerful medicinal agent" at this time, and hence, any and all symptoms which appear during the proving are due entirely to the drug under test. Such an inference, it must be generally conceded, is harmful, because in a proving made in accordance therewith many symptoms may be accepted as drug results which are due to other causes, and consequently in constructing rules for future pathogenetic work the idea embodied in this section should be omitted, and in its place the necessity for eliminating all possible causes of symptoms during the drug test, should be taught.

Section 141 teaches that the physician is best qualified of all persons for proving drugs. While this is undoubtedly true, the section is capable of doing harm in indiscriminately encouraging physicians to prove drugs upon themselves, *knowing the substance they are testing*. This section should have contained the idea that no prover should know either the name or the nature of the drug under test (even though he be a physician), and that, though undoubtedly physicians make the best provers, yet when they do prove drugs they should do so under the direction of some other physician. The purpose of such a precaution is to prevent either intentional or unintentional deception.

We find in Section 142 at least the semblance of authority for securing alleged pathogenetic symptoms from diseased persons. The section reads as follows: "But how the symptoms produced by a simple medicine can be distinguished among the

symptoms of the original disease, even in those which mostly retain their identity, more especially chronic diseases, is an object for superior discernment, and to be left to the masters in observation."

While it is wise to provide for proving drugs upon persons who are not in perfect health, yet such experiments should be classified as strictly as circumstances will permit. In the foregoing section the symptoms obtained from persons suffering from positive diseased states, are allowed to be classified with the symptoms obtained from those provers who are in the best of health; this is disorderly and unwise, even though done by "masters in observation." The necessity for classification does not seem to be generally appreciated. In the provisions for future provings I would suggest, therefore, that instead of the idea found in this section, that rules be adopted classifying provers into groups according to the degree of health and pathological condition of the individuals, according to constitutional defects or vices, *e.g.*, those suffering from derangement of the mucous membrane to be classed together, those having skin diseases to be classed together, those addicted to alcohol, tobacco and condiments, respectively, to be classed together, etc.

In concluding the subject of how drugs should be proved, Section 144 reads as follows: "A *materia medica* of this nature shall be free from all conjecture, fiction, or gratuitous assertion—it shall contain nothing but the pure language of nature, the results of a careful and faithful research." This section is capable of misleading, because, from what we have seen, though all the directions given in the *Organon* for proving drugs be strictly observed, we would not have a *materia medica* "free from all conjecture, fiction, or gratuitous assertion." The rules laid down in the *Organon* leave too many opportunities for the assertion of the "personal equation," to be productive of so perfect a piece of work as is stated in Section 144, even if all experiments were conducted by the strictest Hahnemannian ascetic.

In the foregoing remarks the endeavor has been to consider, more than to answer, the propounded question in an impartial manner, regardless of all theory and opinion, but in accordance with the truth and for the sake of the truth. As a result, we find that the proving of drugs by the average experimenters

(and they have formed so large a majority that the small minority stands apart as a conspicuous exception) has deviated from the rules laid down by Hahnemann in the *Organon*, not merely at minor points, but vitally, and hence the failure to secure a *materia medica* "free from all conjecture, fiction, or gratuitous assertion" can not be charged to deficiency in Hahnemann's rules, because these rules have not been fairly tested; but at the same time we have also discovered that the Hahnemannian rules fall far short of, and differ vitally from, the requirements of "modern scientific research." This inefficiency, however, is not due to any lack of appreciation of requirements on the part of the founder of homœopathy, but it is rather due to the fact that scientific research had not at that day evolved the present critical methods. Hahnemann formulated the most critically scientific rules possible at his time, and there is no reasonable doubt—to judge from his general breadth of thought—that were he now living, he would be the first to encourage this movement of progress, because it is Hahnemannian in spirit.

In consequence of the state of affairs to which attention has been called, it behooves us, as exponents of the art of medicine and of the science of homœopathy, to encourage this Hahnemannian spirit, and in the near future to formulate a proper code of regulations embodying the Hahnemannian idea, but framed in accordance with the "methods and precautions of scientific research."

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#### SOME UNUSUAL MANIFESTATIONS OF HYSTERIA.

BY N. B. DELAMATER, M.D., CHICAGO, ILL.

(Read before the American Institute of Homœopathy, Detroit, June, 1896.)

MR. CHAIRMAN AND DOCTORS: It is my pleasure to present for your consideration a few selected cases of hysteria in which the manifestations are out of the usual order. I will not tire you with full detail history of each case, but must beg your indulgence and patience to sufficient detail to show what each case is.

Miss P., 15 years of age; American; wealthy family. Posi-

tively nothing in family history on either side except a nervous temperament. No disease, no dissipation, no mental bias. The patient as a baby did not sleep as the others of the family, but was restless and uneasy. When about 2½ years old frequent attacks of earache; also frequent attacks of spasmodic croup. Until 9 years of age slender, then began to grow stout and develop generally. When about 10 was standing on the beach and saw a man drowned. This made a very profound and lasting impression on her. To this day cannot bear to go back to that beach.

First menstruated at 11; painless, rather profuse, perfectly regular the first year, since then inclined to slight delay. At one time three months and at another two months interval. Still no pain, always fairly free and perfectly normal in color and consistency. No leucorrhœa, and no abnormal sensations in the genital region. School life shows no possible cause of harm. No urinary symptoms. Bowels regular. When about 13 an attack of what was diagnosticated as la grippe, was quite sick two weeks, the most marked and serious manifestations were in the ear. There was middle ear inflammation, formation of pus, rupture, partial discharge, rapid closure. Middle ear trouble remained and was treated by aurist for some time. The local ear treatment very painful, no outcry from patient, but on several occasions followed by nervous or hysterical condition for some time. Later, an operation under an anaesthetic; following this quite a serious general nervous time.

During this time began to have frequent attacks of headache. Very severe, changed location from time to time, with face flushed, eyes injected and sensitive to light. Brought on by excitement or jar; able nearly always to determine immediate cause; last one or two days, scarcely a week without an attack; menstruation makes no difference.

About this time the death of very dear friends caused two severe mental shocks. She now developed a series of epileptoid seizures. Careful inquiry into the special attacks clearly indicate that they are hysterical; has them from one to three times a month.

A very affectionate, demonstrative nature; a full, voluptuous form, rather large, prominent lips. A low, quiet talker, but exceedingly quick in motion. Never still, always in motion.

*Physical Examination.*—Eyes, slight hyperopia, + .25; corrected; disc and fundus normal; ears, normal, except slight cicatrix drumhead; nose and throat normal; chest, lungs normal; heart normal; abdomen normal to percussion, auscultation and palpation; pelvic region perfectly normal; clitoris perfectly free; spine, some sensitiveness to percussion or pressure over seventh cervical, fourth, eighth, ninth and tenth dorsal vertebræ; a general increased cutaneous sensitiveness; reflexes all normal. A diagnosis of hystero-epilepsy due to strong nervous temperament and mental shocks was made.

A month later attended the Columbian Exposition, was there walking about all day. There was no sprain, no turning or twisting of legs, feet or body, no injury in any way. Got very tired; along in the afternoon began to have a sharp, darting pain in right hip severe enough to interfere with walking. Saw her again four weeks later, still had severe pain in the right hip, also in right knee, most severe around the knee-cap, also some in the heel; any jar was painful; when undertook to bear weight on that foot in walking caused a sharp pain in the hip, and the leg gave way under the pain, rendering walking almost impossible. Had seen two prominent surgeons, who diagnosticated it hip-joint disease. On careful examination I found a fairly clear case, but without characteristic position, also that the aggravation came whether leg in such position as to make blow on the heel communicable to hip-socket directly or not. Learned, on asking direct questions, that her most intimate girl friend had been suffering a good while from genuine hip disease. On getting the patient to describe her friend's case, found she had all the symptoms her friend had told her of. Urinalysis, quantitative and microscopical, showed nothing abnormal. Had Dr. N. Senn and Dr. Charles Adams examine her for hip-joint trouble; decided there was none. Diagnosticated another manifestation of hysteria. The subsequent history and cure confirmed this diagnosis—the cure being brought about entirely through suggestion.

CASE II.—Miss L., 21 years of age; a blonde; very nervous temperament. Father and mother both excessively erratic and nervous. Going over the history carefully failed to reveal any attack of sickness, anything in school life, any nervous shock,

any injury, or, in fact, anything that could be considered a factor in producing present condition, except that at 12 years of age had a very severe attack of diphtheria, in the course of which there was local poisoning or infection in one eye and in thumb. Post-diphtheritic paralysis followed, causing ptosis of eyelid, had to carry arm in sling some weeks. An entire recovery, however, and no indications of any paralytic conditions since.

The menstruation irregular, at times somewhat painful; rather scant. No leucorrhœa; no special symptoms of trouble in genital region. Bowels regular.

A few months previous diabetes, passed large quantities of urine containing sugar, but did not feel badly at the time; lasted about three weeks; was not drinking wine at the time. Had a fall on sidewalk about three years previous; struck on back of head, but no immediate bad results. Since, however, has had a good many attacks, always the immediate result of some mental or emotional disturbance, in which would seem to lose consciousness for a few seconds and show convulsive signs. Is of a very full, voluptuous habit and appearance; lips full, large, red; florid complexion. For some time now has had none of the epileptoid attacks, but has had constantly during waking hours a tremor of both hands, sufficiently marked to interfere with writing or needlework, cannot raise a cup or glass to her mouth at all nearly full without spilling part of the contents.

I find her at my first visit suddenly attacked with blindness and deafness, also a complete paraplegia of upper extremities. Am unable to learn of any immediate cause for this attack.

The physical examination shows a very slight hyperopia; a normal disk and fundus; no heterophoria; ears, absolutely negative; nose and throat practically normal; lungs, normal; heart, normal; abdominal cavity, normal; pelvic cavity: Slight vaginitis, but nothing else; clitoris perfectly free, not large, but rather irritable; uterine position normal; superficial and deep reflexes of legs normal; superficial and deep reflexes of upper extremities impossible to demonstrate; no abnormal sensory conditions; the arms seem flaccid and relaxed, no tension and no tremor; urine, 50 per cent. normal for twenty-four hours; urea, 80 per cent. normal for twenty-four hours; phos. acid, 55 per cent. normal for twenty-four hours; uric acid, normal

for twenty-four hours; chlorides and sulphate, normal for twenty-four hours; coloring matter, normal for twenty-four hours; no albumen; no sugar; an abundant sediment, but composed of mucus and epithelial cells.

Careful study and test fail to get any evidence of the present condition being feigned. Can find no sufficient evidence of lesion that can cause present condition. Am unable to find any adequate cause for the tremor.

Later I learned that there was and had been for a long time excessive sexual passion without gratification in any way. Was obliged to give an opinion of hysteria. Case recovered suddenly about three weeks later, as the result of a fright. Recovery complete.

CASE III.—Mr. B., 26 years of age, well built, rather firm muscle, good, well-proportioned form. A musician, amateur, but quite enthusiastic, also on the Board of Trade. Very sensitive and retiring. Always having his feelings hurt, but makes no comments; grieves over these things, but no demonstration.

The history, family and personal, absolutely negative, except is bothered a good deal with sexual passion, masturbated not to exceed eight or ten times when about fourteen years of age; never at any other time; has never had sexual intercourse.

For about eighteen months has had a decided tremor of the head, with some tremor in both hands. A short, fine tremor will pass away when playing any instrument or when very much interested in any special thing. No tremor when asleep, but constant, except as above, when awake.

A very full and careful inquiry fails to develop anything else in the case except that he had impressed on his mind a case of apparent paralysis agitans, supposed to have been caused by self-abuse. A complete physical examination gave absolutely negative results. Was forced to call this a hysteria. Several very plain talks with the patient by my partner, Dr. C. T. Hood, telling him exactly what I considered his case, also that no possible harm could result from that amount of masturbation, convinced him apparently fully and completely that we were right, and a gradual improvement set in, so that in a short time there was no tremor except for short periods, and these quite infrequent. Marriage took away the last vestige of the trouble.

CASE IV.—Mr. B., 36 years of age, tall, angular, but not markedly emaciated. Family history, including father's and mother's families, also brother and sister, reveals a very slight rheumatic tendency, and two cases of cancer in father's family, but not in immediate line. Nothing else.

The patient's history reveals attacks of sick headache when six or seven years of age, always relieved promptly, however, by an emetic of ipecac. These attacks ceased entirely when twelve years old. Very little school life. When about twelve years of age a horse fell with him on the ice, struck on the back, was unconscious an hour or two, back was lame a week or so, then apparently all right. When about twenty years old was affected by the heat sufficiently to grow dizzy and weak; was unloading logs; slipped and log rolled onto him, compressing chest quite seriously; was rather faint and weak, but nothing more. Was weak and could not do any work to speak of for about eighteen months; a good deal of pressure in chest, and also an obstinate constipation; some palpitation of the heart at times. Began to feel generally nervous and to worry over everything. Up to this time had to endure a good many hardships; was in a new country, very cold winters, insufficient clothing, etc. Went to work in a drug store and then studied medicine; commenced practice, and was married when about twenty-three, and for a time very much improved in every way. Then began to have catarrh badly, followed later by asthma. Finally gave up the practice of medicine and changed climate; went to farming; the catarrh and asthma practically cured by this. During this time had a good deal of leg ache, with occasional sharp pains in the knees—one or both—also a general feeling of muscular lameness on the least exertion.

The present trouble began with the eyes; some defect in vision at times, occasionally double vision, with it a considerable headache. Had a double cyclotomy on the eyes, but later learned the defect in the disk was congenital and physiological. Still has occasional spells of trouble with the eyes; commences with a general nervous feeling, then a dull grating feeling over head and in eye, then a general kaleidoscopic appearance before the eyes. Covering the eyes or lying down and closing the eye will always relieve in a very short time.

There is always with these a feeling as if he might be nauseated. The next day the mind is apt to be clouded a little, memory not clear, gets the wrong words, etc. (This lasts a few hours only.) But during the attack can, by covering the eye, make the mind work all right. Following the operation began to have a considerable disturbance of digestion. That is, gas in stomach and bowels; would gulp up and pass per rectum in quite large quantities. The character of food seemed to make no difference as to quantity of gas. It was tasteless and odorless.

Right after the operation, that is, only a few days, asleep at home, a train accustomed to going through in daytime, delayed, came through between eleven and twelve at night, stopped with engine right in front of house and blew off steam; wakened him in great fright; could not go to sleep again. From that time for months, could not see a Mogul engine (the make of this one) or hear one blowing off steam without fright. No other make of engine affected him at all. Even yet gets a start, only momentary, to be sure, if one starts to blow off. Sleep has been very much disturbed ever since this time. Sometimes he thinks because of a desire to urinate; has been obliged to get up at night to urinate ever since that time. The constipation is quite severe; uses glycerine enemas a good deal. The stool not constipated, but difficult to expel. At times thinks cannot feel urine or fecal matter when expelled. Thinks some anesthesia of the parts. Still has a good deal of pain in the legs; at times calls it rheumatic; at others is sharp and darting. Cannot walk about in the dark; staggers all over. As to habits, never masturbated, no sexual intercourse previous to marriage, not at all excessive since. No impotence now or at any time, but less desire than formerly. Never used liquor or beer. Never chewed tobacco and smokes two or three cigars a month only, and never has more.

Physical examination shows: Eyes,  $1\frac{1}{2}^{\circ}$  exophoria; a very slight astigmatism, there has never been any glaucoma; ears, normal; nose and throat, slight catarrhal follicular; lungs, normal; heart, normal; liver, some sensitiveness, not marked, over anterior lobes; no enlargement or misplacement.

A general tenseness of abdominal walls, especially sensitive over region of stomach, but no increased area of dulness and no nodules. The portal circulation rather sluggish.

Penis, no stricture, nothing abnormal, except possibly a little hypersensitive; rectum, quite an ulcer between internal and external sphincter anterior; no haemorrhoids; superficial reflexes normal; am unable to get any knee-jerk; cutaneous sensations apparently normal, heat and cold tests reveal nothing abnormal.

Gait suspicious of ataxy, with eyes closed, feet put down irregularly as in ataxy, with eyes turned to ceiling and head thrown back the same; with eyes closed can stand firm, on one or both feet, with or without shoes; has no difficulty in putting foot on step in getting into a buggy without any assistance of the eyes; can put his foot on round of chair with eyes closed; can keep eyes closed, and do this with either foot, changing them as directed, or change from round to seat of chair; does this quite accurately, and barefooted or with shoes; does not walk with eyes closed when barefooted; no tendency to any one direction; nothing revealed by percussion or pressure over spinous processes.

In walking or standing with eyes closed, if undertakes to turn around, must steady himself, specially a little.

Urine, twenty-four hour quantity normal; urea, 75 per cent. normal for twenty-four hours; phosphoric acid, 40 per cent. normal for twenty-four hours; total salts (less urea), deficient; chlorides and sulphates, normal; coloring matter, normal; no albumin, no sugar, no blood, no pus, very little mucus, no crystals, no casts, only usual epithelium, thus showing nothing except great deficiency in excretion of phosphoric acid.

At this time, unable to make a diagnosis, the case was certainly very suspicious of locomotor ataxia. Concluded to keep the patient under observation a month before giving an opinion. During this time tested the reflexes a number of times; found that by having him sit in a favorable position, and engaging him in general conversation, as his mind was not on his malady at all, I could, by sudden and unexpected taping, get a fair knee-jerk, but never could under other circumstances. Found also that the gait-tests varied from time to time very materially; also that some minor things I told him belonged to ataxy sprang up at the next interview. I had him take the hypophosphites of lime and soda during this time, which gradually seemed to clear up the urinary symptoms, so that at the end of

the month he was passing a normal amount of urea and 80 per cent. of normal phosphoric acid. I then gave an opinion of hysteria simulating locomotor ataxy. I learned later from the physician with whom he studied medicine that his mind seemed full of this particular disease at that time, and that he had for many years read everything he could find on this particular subject.

The subsequent history of this case, a period of six years, fully confirmed this diagnosis. The ataxy is entirely cured.

CASE V.—Mrs. D.; 34 years of age; widow; never pregnant. Father a hard, steady wine drinker, also an excessively heavy smoker. Is, and has for years, been semi-narcotized by these agents all the time. Was excessive in both habits before birth of this daughter. There were two cases of insanity in his family. The mother is dead; was a very nervous woman and had a paraplegia for some years previous to her death. A sister of the patient has for years been verging on the border of insanity, a son of this sister is feeble-minded and epileptic. A brother of the patient is insane. The patient was a fairly healthy and level-headed child and young woman. Menstruation commenced at thirteen; has always been regular and practically painless. Has never, and has not now, any symptom pointing to uterine trouble. Was married at twenty-five; her husband lived less than a year; died from an acute trouble of only four days' duration. No sickness until about eight years ago; then an attack of typhoid fever, sick six weeks, was in a somnolent or stupid condition for a considerable time, but made a good and apparently complete recovery. Five years later an attack of bilious fever; not severe; sick three weeks; a quick and complete recovery. One year later an attack of inflammation of the bowels, in bed a month, was quite sick. Thinks she has never felt quite as well since. Has considerable bloating of abdomen, feeling of fulness, eructates quite a little tasteless gas at times. It does not seem to make any difference as to the kind of food she takes. It will sometimes produce the bloating and uncomfortable feelings and sometimes not. Urinates frequently; it is quite clear many days when quite a quantity, other days normal. Is in good flesh. Used to have frequent attacks of headache, pain in back of head and neck, head seems to be drawn backward, face flushed, sharp pains

through the temples, always relieved by hot applications. The heart is irritable; that is, it beats rather forcibly and rapidly under slight excitement. Some five or six years ago walking along, if a horse and carriage came up behind her suddenly, or any sudden shock occurred, she would fall on to her knees—nothing more; no loss of consciousness. There was with it a sort of blindness and vertigo lasting only a few seconds. Get up almost instantly and go on as if nothing had happened. Later found when out in the street, especially if any extra bustle, that her legs were heavy, that they did not seem to want to work right; as though she would stagger. Would take hold of fence or touch walls of building to keep herself from staggering. Later the feet began to drag, to scuff on the walk somewhat, so it is now quite difficult for her to walk in the street even when everything is very quiet. The dizziness and the heaviness of the legs is almost constant when out of doors, but very little if in the house, but cannot walk fast even in the house. The gait very much like early stage of spastic paraplegia.

*Physical Examination.*—Eye, negative; nose and throat, negative; lungs, negative; heart, negative; abdomen, negative; genito-urinary, negative, as also the rectum.

*Gait.*—Can stand or walk with eyes closed all right, except there seems to be a constant tendency toward the left and to scuff the feet on the carpet. There is a little of the lifting of the legs, by a motion of the body, and an apparent effort to bring the legs forward. The superficial reflexes all right; the knee-jerk slightly exaggerated, possibly; no ankle clonus; no atrophy or contracture; urinalysis normal, except at times when in excess, and then simply dilute.

In this case I was very much puzzled to make a diagnosis; was inclined to an opinion that there might be some bulbar lesion. The fact that she walked so much better in the house at home than out of it or in my office, that is, when her mind was essentially on her household; that any sudden excitement always increased her trouble; that she would always be markedly worse when environments were such as to allow her to study herself; that the symptoms were mixed, some of them apparently being spinal, others cerebral, and that the motor symptoms, the reflexes, and sensory conditions were not

in accord; in short, that a lesion producing just the combination present was impossible, combined with the fact that I could not make out two distinct lesions, forced me to the conclusion that I had a hysteria simulating paraplegia.

This case recovered entirely without treatment. I do not intend to say she had no treatment, for she did have a good deal, but later on environments became such that it was impossible for her to get treatment, and to demand and engross her entire attention outside of herself, and some time later she suddenly realized that she was perfectly well.

I have selected these five cases for the purpose of presenting a few thoughts for consideration. In all of them we have marked motor symptoms, loss of motion, tremor, or inco-ordination. In three of them we have remarkably close counterfeits of well-known organic lesions; in the other two, symptoms that might result from organic lesions in part at least.

There is a remarkable absence of sources for reflex irritation. In the first, a very slight hyperopia, which was not corrected; in the second, nothing; in the third, nothing; in the fourth, a slight exophoria, astigmatism, and a rectal ulcer. In this case there would be sufficient to account for hysteria, but not for the peculiar manifestations; and in the fifth, none.

In all there is present a neuropathic element. Two cases are males, three females. My experience has been that in the male the simulation of established, well-defined organic lesions is closer and retention of the type more uniform than in the female. This I attribute to the fact that, as a whole, the mind has been more fully developed in the systematic lines and in observation.

In all the cases there was suggestion in the direct line of the symptoms presented, objective and subjective. It has been my experience that in all cases of hysteria at all closely resembling any well-defined organic disease, suggestion has been present as a possible factor in determining the course. I am unable to account in any other way for the wide and varied manifestations. I cannot but believe that they are all alike in essential entity. Hysterias differ in etiology, and in their course and symptomatology very widely, but it is always the same disease or condition, whether it occurs in the course of other diseases or is idiopathic.

It is not my purpose to enter the field of treatment in this paper at all. I fully and firmly believe that, if the medical profession once gets a thorough grasp of this disease *per se*, the successful cases will multiply very greatly. I also believe that, if we comprehend that it is possible for this entity to simulate, both subjectively and objectively, well-defined or ill-defined lesions, we will put much closer study on all cases that present to us, and will find very many amenable to treatment that now go through long years of torture and hopelessness.

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### A FEW STRAMONIUM CASES.

BY SELDEN H. TALCOTT, A.M., M.D., PH.D., MIDDLETOWN, N. Y.

(Read before the American Institute of Homeopathy, June, 1896.)

STRAMONIUM is a remedy which occupies a unique but interesting position in therapeutics. It has generally been classified as a "powerful narcotic agent." It was formerly used for the alleviation of pain, and some of the famous liniments and ointments of medical commerce were largely saturated with the juices of the stramonium plant.

While its general action tends to the production of insensibility, it does not work in a soporific or sleep-producing manner. The relief of pain, without the production of sleep, but by causing an insensibility of the nerves, is one of the primary effects of stramonium. The secondary effects appear when this temporary insensibility passes away, and when, by a process of reaction, hyperesthesia is established throughout the great nerve centres, and, as a natural consequence, there is a marvellous hyper-stimulation of all the mental powers, especially that of the imagination.

The patient who is just released from the primal insensibility caused by stramonium, and stirred by the inevitable reaction, is in the condition of a person who suddenly wakens from a horrible and devastating dream. He is in a condition of abject fear. All the energies of the mind seem bent upon conjuring up the most terrifying images of devouring monsters, and these vivid creatures of the imagination seem, to the frightened victim,

about to crush and destroy and tear asunder the minutest fibres of the physical temple. The most appalling visions of dragon and gorgon and apocryphal wild beast are born within the brain of the victim or prover of stramonium. Under the influence of an excited imagination (the effects upon the cerebrum of this peculiar and overpowering drug), the prover sees strange animals coming from all corners of the room. He sees trains of bed-bugs, and processions of beetles, and hosts of cockroaches. He sees ants and bugs, and rats and mice, and frightful figures of many direful shapes and forms. He sees his own executioner. He sees lizards, and worms, and snakes. He hears voices of men talking in foreign tongues. He feels that a dog is biting and tearing the flesh from his chest. These hallucinations of sight and hearing and feeling all impel the victim to a condition of profound, abject, cowardly and retreating fear. Similar mental states are observed in acute mania, in delirium tremens and in acute delirious mania. In medical practice, such states and symptoms call for the use of stramonium. Whenever we find intense physical and mental excitement, coupled with abject and profound fear—a fear that is demonstrated by the most positive expressions of horror—then we may administer stramonium with confidence in its ability to effect relief. A peculiar numbness, or insensibility, often precedes the maniacal outbreak.

Belladonna is intensely excitable, and periodically pugilistic. Hyoscyamus has a jolly delirium, with tendencies to obscene abandon. Veratrum alb. has a violent mania and religious aspirations, or religious apprehensions, coupled with a condition of physical collapse. Stramonium has all the physical unrest of the remedies which we have named, and likewise all the maniacal excitement of these three drugs. In addition, stramonium has those sensations and fears which must have filled and overpowered the heart and soul of Prometheus when he was bound upon the rock, where for thirty years he suffered those physical tortures which were relentlessly administered by the beak and claws of the devouring vulture which fed upon his liver.

We will now present a few cases from the records of the Middletown State Homœopathic Hospital, showing the symptoms and mental states of some of our patients to whom stramonium was administered. The results are also stated. These

cases illustrate the fact that stramonium very quickly relieves patients suffering with numbness and insensibility, or with great maniacal excitement; to these are added abject and cowardly fear, and vivid hallucinations of sight, hearing and feeling. The hallucinations usually relate to animals of a fear-producing variety. Sometimes fright is induced by visions of very bright objects, such as sparkling water, or sunlight, or stars.

CASE No. 1 (No. in case-book, 4573).—Female; admitted December 23, 1895; age, 44; married; number of children, 5; living, 5; nativity, United States; occupation, none; education, collegiate; habits, temperate; condition, exalted; present physical condition, fair; pupils, dilated; bowels, normal; appetite, good; weight, 145; number of attack, second; age at first attack, 37; duration of attack, two weeks; remote cause, predisposition; exciting cause, unknown; diagnosis, mania; stage, acute.

December 28, 1895.—Very excited; hallucinations of sight and hearing which frighten her terribly; face flushed; restless; constantly in motion; very noisy; takes plenty of milk, but no solid food; spits a great deal. Stramonium 3x hourly. Slept five hours; very noisy the latter part of the night. 29th.—Says the hallucinations are less vivid; slept three hours; quite noisy. Says she wants to go home, as she is frightened here. Face flushed; skin moist. Sees all kinds of things in the room; "tall man, thin woman, two faces over the door." Can see these horrible faces during the day; complains of steady pain across the lower part of the back, time for menses to appear. 30th.—Restless, noisy, and awake every hour. Temperature, 99°. 31st.—Slept none. Passiflora and stramonium. January 1st.—Slept none; noisy at times; took nourishment during the night. Temperature, 100°. This condition continued until January 5th, when she began to get quieter; sleeping better, and taking plenty of food (liquid). 6th.—Unusually quiet, and taking plenty of milk. 9th.—Quiet, and slept well. 10th.—Bright and quiet. 18th.—Sleeping well; out of protection sheet; thinks she sleeps better; improved. 21st.—Crying, and unusually excited this p. m. 23d.—Slept well last night; is steadily improving; is put under a protection sheet at night; says she likes it; it keeps her warm. 26th.—Says she feels better than she ever did in her life. Patient continued to im-

prove from this time on, and left the hospital recovered May 4, 1896.

No. 2 (No. in case-book, 3141).—Male; admitted April 1, 1891; age, 31; single; occupation, clerk; education, common school; habits, intemperate; heredity, none; father and mother first cousins; present physical condition, feeble; temperature,  $99\frac{4}{5}^{\circ}$ ; remote cause, predisposition; exciting cause, intemperance; diagnosis, mania acute, afterwards delirious.

April 24th.—Very nervous; pupils dilated; can hardly hold still at times; twitching of muscles all over; rambling and unnatural in conversation; acts as if bordering on delirium tremens; great fearfulness, as if afraid of being injured by imaginary foes; takes his nourishment fairly well; vomited last night. Was given stramonium 3x every half-hour. 25th. Yesterday afternoon became violent. Saw rats and insects; became afraid; jumped out of bed, and curled himself up in a corner of the room to get away from snakes, etc. Thinks the house is falling down on him. Was given aconite 1st hourly, followed by stramonium 1st hourly. Very restless and noisy during the night; slept none; violent this morning; at times becomes very scared and apprehensive; appears to see horrible things about him; calls out in terror; perspires freely; talks irrationally, and incoherent this morning; face flushed; pupils dilated; very tremulous. Stramonium continued in 3d decimal dilution. 27th.—Rational this morning; temperature,  $99\frac{4}{5}^{\circ}$ ; pulse, 100; respiration, 26; took liquid nourishment, lying quietly in bed; face flushed; continued to improve from this time on. Discharged recovered October 16, 1891.

No. 3 (No. in case-book, 4415).—Male; admitted May 22, 1895; age, 11; single; nativity, German; occupation, none; education, common school; habits, temperate; present physical condition, fair; weight, 68; number of attack, first; age at first attack, 2 years; duration of attack, 9 years; accompanying disease, epilepsy; remote cause, predisposition; exciting cause, meningitis; diagnosis, epilepsy.

It is said that this boy will have a fit at the sight of a stream of water. He will not speak or give any sign that he understands what is said to him; seems afraid of everything and inclined to get away from people. Stramonium 1st every two hours, 25th.—Brighter; does not eat well, 28th.—Answers

all questions by giving his name. 31st.—Masturbates constantly; having many fits. July 3rd.—Restless; walking about constantly. September.—Every time he hears any sharp or sudden sound has a fit. Was given belladonna. October.—Never speaks; constantly playing with his penis. 17th.—The slightest sudden noise scares him into convulsions; had stramonium 3d. November 28th.—Doing better; growing fleshy; not masturbating; has not had a fit for six weeks. December 18th.—Very much brighter; talks in German; growing fat and strong; no fits. 28th.—Gradually growing stronger; no fits. January, 1896.—Bright and lively. This case had stram., bell. and podo. After taking stramonium a second time the fits ceased, and he has had no recurrence of convulsions during the past nine months.

No. 4 (No. in case-book, 4483).—Female; admitted August 13, 1895; age, 44; single; nativity, United States; occupation, none; education, common school; habits, temperate; heredity, uncle and cousin; present physical condition, feeble; pupils, dilated; bowels, constipated; appetite, poor; weight, 103; number of admission here, third; other hospitals, 2; age at first attack, 34; duration of attack, two months; remote cause, predisposition; exciting cause, worry and overstudy; diagnosis, mania recurrent.

Patient has been home on a parole. Returned April 10, 1896. Says her head feels numb; sees stars all the time; sensation of sailing around; must keep her eyes closed; sees stars either with eyes opened or closed; seems coherent and fairly well composed; does not keep her hands constantly in motion as she always has done when here before; winks much; not so haughty. 13th.—Says she slept better, but that her head feels just as bad as ever; is numb at times, and at times it throbs and beats; is afraid of everything. Stramonium 3x every two hours. 14th.—Says she feels better to-day; does not see the stars or bright lights as she did; head does not ache; slept six hours last night; eating better; 16th.—Continues to improve; says she feels perfectly natural and well again. Was given sac. lac. three times a day. 30th.—She again complained that her head felt weak and bad. Was given stramonium 3x every two hours one day. May 1st.—Head feels much better to-day; feeling better in every way. Paroled June 3, 1896, very much improved.

No. 5 (No. in case-book, 2763).—Male; admitted March 12, 1890; age, 42; married; number of children, 5; nativity, United States; occupation, cutter; tendencies, threatened homicide; heredity, maternal; present physical condition, feeble; pulse, 100; temperature  $99\frac{1}{2}$ °; weight, 140; number of attack, first; duration of attack, two and a half months; remote cause, physical disease; exciting cause, morphine habit; diagnosis, melancholia; stage, acute delirious.

March 16th, 1890.—Pupils widely dilated; eyes inflamed; hallucinations of sight; mistakes the identity of persons; talking disconnectedly and irrationally, but will occasionally answer sensibly; looks for different things in the bed-clothes; terribly apprehensive and fearful of injury. Stramonium 1st every two hours; improved steadily after taking stramonium; unnatural symptoms subsided, and he was discharged recovered May 15, 1890.

No. 6 (No. in case-book, 3594).—Male; admitted August 25, 1892; age, 37; single; nativity, United States; occupation, farmer; education, common school; habits, intemperate; present physical condition, feeble; pulse, 100; tongue yellow; temperature,  $98\frac{1}{2}$ °; bowels, constipated; appetite, good; weight, 135; gait, unsteady; heart, irritable; skin, sallow; number of admission here, first; age at first attack, 37; duration of attack, three weeks; remote cause, predisposition; exciting cause, intemperance; diagnosis, mania; stage, acute.

Has threatened to kill those who take care of him; has done so repeatedly, and when not under the influence of stimulants; wanders about the house at night; imagines that robbers are in the house; eats ravenously to the extent of gluttony; he eats a dozen cans of corn or peas raw at a time; his symptoms are not the result of alcoholism, as they exist when he has not been drinking.

On admission, depressed, ugly; does not sleep nights; sees strange things; sees "niggers and strange men trying to get into the house." All symptoms are worse at night; soiled his bed at night; said it would have to be proven, as he was in so many beds during the night; delusions; thinks he sees women in the ward; irrational; they all cry "down on C., shoot C., kill him, shoot him." Hears voices from the radiator; says he feels scared at times; does not know why. Stramonium 1st

every two hours was administered, and all the symptoms in this case were quickly relieved. Under the effects of stramonium this patient made a satisfactory and happy recovery, with no return of his disorder.

No. 7 (No. in case-book 4119).—Male; admitted April 20, 1894; age, 26; single; nativity, United States; occupation, stone mason; education, common school; habits, temperate; fair physical condition; number of admission here, first; number of attack, first; age at first attack, 26 years; duration of attack, three months; remote cause, predisposition; exciting cause, ill-health; diagnosis, mania; stage, acute.

June 4, 1894.—Says he sees lice; is very violent; has to have mitts on; face red, but pupils not very dilated; expression of fear on his face constantly; was given stramonium 3d every two hours. 5th. Has not seen lice since he began taking stramonium; is more quiet and sleeping this morning. 23d.—Very thirsty; wants water every fifteen minutes. Stramonium 3d, every two hours. July 14th.—Wants to chew everything; howls like a dog; had cantharis every two hours. 23d.—Sleeps from three to seven hours nightly; appears to be gradually growing more quiet; at times violent; continued to improve mentally, but had several intercurrent remedies for colds, etc. Discharged recovered June 20, 1895.

No. 8 (No. in case-book 4158).—Male; admitted June 11, 1894; age, 55; married; number of children, five; nativity, United States; occupation, bayman; habits, temperate; attempted suicide; present physical condition, fair; age at first attack, 55; duration of attack, one month; accompanying disease, rectal ulcer; remote cause, predisposition; exciting cause, worry and sickness; diagnosis, melancholia; stage, acute.

June 18, 1894.—Very restless and noisy; calls for water, then yells when it is brought, that "it will set the world on fire;" appears to be afraid of it; mouth and tongue dry; very apprehensive; stramonium 3d hourly. 19th.—Restless; at times gives utterance to many delusions, but when spoken to will say nothing. 26th.—Is slowly improving; has but little to say; continued to improve steadily, and discharged recovered October 24, 1894. This patient has remained well since leaving the hospital.

In the treatment of mental diseases, so-called, we find that

the more carefully and accurately the homœopathic remedy is applied according to the "totality of symptoms," the more surely the patient is relieved of both mental distress and physical degeneration. At the same time we cannot rely wholly upon the effects of any remedy. The causes of mental disorder must be removed; the sanitary conditions which surround the patient must be the best that are known to modern science. Mental and spiritual hygiene must be applied with scrupulous care. The means and measures for rebuilding the physical forces by the use of suitable diet, given under proper conditions, must be attended to with religious perseverance and fidelity. As each remedy should be given according to the "totality of symptoms," so, in the reconstruction of a degenerate human system, the totality of advantages and opportunities must be strenuously monopolized.

In the administration of drugs for the cure of mental and nervous disorders we should exercise profound patience, and calmly await the effects of a selected remedy without introducing new and unnecessary drugs. Sometimes we are in such a horrible and hustling hurry to accomplish the desired end that we do not wait to secure the best and happiest results which might follow the persistent use of the indicated remedy.

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#### WOUND TREATMENT.

BY WOODWARD D. CARTER, M.D., PHILADELPHIA.

(Read before the Rousseau Clinical Club.)

In introducing the subject of wound treatment for your consideration to-night it is my purpose to describe, in brief, the methods and various antiseptic substances employed in treating wounds as we meet them in the surgical department of the Hahnemann Hospital Dispensary.

With such an object in view a discussion of the various causes of non-union, the bacteriology of suppuration, the controlling of haemorrhage and the processes of healing, etc., would be superfluous.

It is also assumed that you are the possessors of antiseptic

consciences, so that it is not necessary to describe the preparations for an operation, regarding care of patient, instruments, dressings, surgeon and assistants, etc., only to remind you that every subsequent dressing requires the same care as does the primary. In speaking of the treatment of wounds, we must understand that the treatment will vary according to the various circumstances of the case. We must therefore discuss the treatment under these varying conditions. Wounds may be divided into three great classes:

1. Those which are made through previously unbroken skin and which do not communicate with mucous surfaces.
2. Those which are made through mucous membrane, or which, if made through skin, communicate with some mucous canal.
3. Those which are subcutaneous.

Such a division is necessary because, while in the first class of cases it is comparatively easy to exclude micro-organisms, in the second class this is practically impossible.

The first class of cases may again be subdivided into :

1. Wounds which have been made by the surgeon through previously unbroken skin.
2. Those where the wound is quite recent, but has not been made by the surgeon.
3. Where the wound, also not made by the surgeon, has existed for some days, or where, in the case of wounds made by the surgeon, sepsis has followed.
4. Wounds of still older date which have assumed the form of sinus or fistula. The first division, *i. e.*, wounds made by the surgeon through previously unbroken skin, is again capable of subdivision into wounds where the skin edges can be brought together and those which cannot.

Where the skin edges can be brought together our thought should be to secure primary union.

Bring the skin edges into accurate apposition. A puckering wound or overlapping of one edge will either cause part to heal by granulation or sloughing of the overlapping edge.

If there is much tension, in addition to the apposition sutures, relaxation sutures should be placed a short distance apart and about one inch or more from the skin edge.

In deep wounds subcutaneous sutures should be used, stitch-

ing fascia to fascia, muscle to muscle, etc. The best material for this purpose is a suture which will absorb. Non-absorbable sutures will in the majority of cases irritate the wound, cause non-union and finally slough out. Recently brilliant results have been claimed for silver wire as a subcutaneous suture, the claim being made that it is aseptic in itself. If the statement is true, that the reliability of a suture depends upon its freedom from noxious germs, then in silver wire we have reached the ideal, but the thought that it is also a foreign body, and as such may irritate, should lead us to adopt a conservative middle course until its worth is fully proven. If much oozing is feared, a small piece of sublimated iodoform gauze should be placed in the most dependent parts of the wound for drainage. This can be removed in twenty-four to forty-eight hours, and healing will go on without interruption.

The dressing can be wet or dry; of the latter iodoform and boric acid 1:10, aristol or vitogen are the best. Wet dressings for the first are probably better because they absorb any oozing from the cut surfaces and do not dam discharges back as do dry powders.

The wet dressing most frequently employed is sterile gauze wrung out of solution of bichloride of mercury 1:2000. If any oozing appears on the surface more gauze can be placed over it without removing the dressing.

To avoid objectionable stitch marks, the following method is employed: A fine needle, threaded with catgut, is introduced to include the corium only, make a continuous suture, and bury the knot under the skin. Dress with iodoform and collodion or Socin's paste:

R.	Zn oxide,	.	.	.	.	.	.	50 parts
	Zn chloride,	:	:	:	:	:	:	5 "
	Aqua,	.	.	.	.	.	.	q.s. to make paste.

The usual method of dressing wounds where the skin edges cannot be brought together is packing them with sublimated iodoform gauze or filling the cavity with sterile iodoform and boric acid 1:10, boric acid or vitogen. The iodoform, however, should be used with care, owing to the susceptibility of some patients to its poisonous action. Large granulating surfaces are skin-grafted by the Thiersch method.

The majority of these wounds will heal readily, but now and then one meets with wounds which resist all efforts at healing, although they may be perfectly free from suppuration. The cause of this may be found in some constitutional dyscrasia, syphilis, tuberculosis, alcoholism or diabetes. The too free use of antiseptic irrigations will also retard healing by irritating the wound and destroying the leucocytes which we have been so carefully trying to nourish. Sometimes our efforts at healing are prevented by the heaping up of granulations, thus preventing the formation of the epithelial layer. It should be our object to get rid of these. The best means to employ is to cut them away with a pair of scissors curved on the flat. This procedure causes very little pain at the time and none subsequently. The use of nitrate of silver is objectionable, as it not only causes pain which lasts for a long while, but leaves a slough which retards healing. A very efficient dressing may be had in bismuth subiodide. This powder dusted over the wound cuts down the exuberant granulations and at the same time exerts a favorable influence towards healing.

Our second division of wounds, those which are recent, but have not been made by the surgeon, are subdivided into incised, lacerated, punctured and contused.

In the case of incised wounds thorough cleansing with soap and brush, carbolic acid 1 : 20, and finally, irrigation with sublimate solution 1 : 2000 should be rigidly enforced. The skin edge should then be brought together, and the wound treated as above.

Usually in punctured wounds the point of entrance is so small that thorough disinfection is difficult. It is accomplished by holding the wound edges open, enlarging the opening, if necessary, and cleaning thoroughly. The wound is then packed lightly with sublimated iodoform gauze, and healing obtained from the bottom.

When we have to do with lacerated and contused wounds, the principles of treatment are essentially the same. Clean the wound, cut away any ragged edges and pack with sub. iod. gauze, or dust with one of the antiseptic powders. Cover the whole with sublimated gauze and bandage.

The third division of wounds are those which have not been made by the surgeon, but have existed for some days, or those

which have been made by the surgeon and sepsis has followed. In other words, septic wounds.

When a sutured wound threatens to suppurate, the indications of which are redness, induration, pain and zigzag temperature, it should receive the most vigorous treatment. Frequent applications (every 2 to 8 hours) of hot bichloride of mercury 1:1000 should be made. Formalin in strong watery solution, 3 to 0, frequently applied, is also very effective. In fact, it has almost come to be regarded in the light of a sure thing. It should be carefully watched, however, as its action upon the skin is to produce a leathery hardness. Our endeavor should be to stop short of this. The tanning process produces a slough which must necessarily separate before healing can take place. Formalin is also an excellent remedy to cure the erythema caused by corrosive sublimate. Several days' treatment of this kind will often turn the tide and save the wound.

Should suppuration be inevitable, our only course is to remove the sutures and drain, making use of one of the pus-killers. Our first resort is peroxide of hydrogen. Not that we have any faith in its ability to prevent the spread of infection, but it will kill the pus already formed; boil out the wound and place it in a condition to be acted upon by some stronger agent. Bichloride of mercury is the most reliable antiseptic. It has, probably, a wider sphere of usefulness than any other antiseptic. Frequent irrigations with a 1:1000 or 1:2000 solution and packing the wound with sub. iodiform gauze, will often be all that is necessary to control suppuration.

Bromine, so highly indorsed by Dr. M. O. Terry, of Utica, N. Y., I regard as a most valuable antiseptic. I have seen the foulest wounds, reeking with pus, under its influence produce healthy granulations in two dressings. The odor of bromine is not agreeable to most nostrils, but this may be overcome by a formula devised by Dr. Rice:

R.—Bromine, . . . . .	120 gms.
Sodi brom., . . . . .	125 gms.
Aqua, . . . . q. s. . . . .	1000 c.c.

This, the stock solution, is to be added to water to make an amber color.

This may be as good as the pure article, but in my hands has not been satisfactory. I prefer bromine pure, made into a

stock solution 1 : 8 and added to enough water to make a bright amber color.

Carbolic acid in 5 per cent. solution,  $6\frac{1}{2}$  3 to O water, is a most effective germicide. The action of this agent is caustic, and therefore should not be used too often; once or twice per day is sufficient until pus has disappeared. Sometimes, in spite of the most thorough dressing with these watery antiseptics, suppuration goes on. Why?

It is well known that for the growth and multiplication of bacteria a certain amount of moisture is necessary. It may be that the bacteria have reached the spore stage and therefore harder to kill, and we have been supplying the necessary amount of moisture for their growth. We have also been irritating the wound and macerating the tissues with strong chemicals in solution.

The indication now is, to stop all irrigation and turn our attention to dry dressings. These are found in the various dusting powders, of which iodoform and boric acid 1:10 stands at the head.

There has been much discussion about the merits of iodoform as an antiseptic, but as the result of much debate it is generally acknowledged that it is not an antiseptic in the ordinary acceptation of the term, that is to say it does not kill bacteria, nor does it even interfere with their growth, but it does break up the products of bacteria, and in doing so is itself decomposed, iodine being liberated, and the presence of this free iodine causes inhibition of the bacterial growth.

Vitogen next. This is an antiseptic which has but recently been introduced, and from the good results which I have obtained from its use I have come to regard it with a great deal of favor. I have seen suppurating wounds which have resisted all treatment finally terminate in a healthy issue by its free use.

The wound should be packed heaping full of the powder, and plain gauze and a bandage applied. A few infrequent dressings of this kind will frequently bring about speedy healing.

Boric acid used in the same manner is also highly effective.

#### SINUS AND FISTULA.

A word concerning these conditions, and that of caution.

During my college days I got the impression that in order to heal, all wounds should be packed to the bottom. A sinus is a condition where this does not always hold good, and is frequently the cause of non-healing. Let me caution you against squeezing out discharges, rough probing and tight packing. You are working against nature. She is trying to heal the wound by throwing out minute bands of granulation tissue and you are breaking them up at each dressing. The sinus should be filled with some dry powder or the mouth kept open with a small piece of iodoform gauze to allow escape of discharges.

Fistula is a condition which so frequently calls for the use of the knife that I will not take time to discuss it.

Subcutaneous wounds are usually caused by great violence—fractures, heavy blows or fall. The result is laceration of blood vessels, with extravasation and swelling. Where there is no large abrasion of the skin the best all-around dressing is Burow's fluid, 24 parts alum, 38 parts lead acetate, 1000 parts water, pieces of gauze saturated and applied evenly to the wound and held in place by a firm bandage. A word of caution regarding the bandage. Where the injury is to one of the extremities, always include the hand or foot to ensure equal pressure and support the circulation. I have made the mistake of applying the bandage without including these members, and I shall never forget the result. Arnica lotion is another good dressing, especially for the contused variety. Calendula lotion has its place where the skin is much abraded. Lead water and laudanum is a good old-fashioned remedy, and should not be forgotten.

#### BURNS AND SCALDS.

Use such dressings as will neutralize the acidity of the tissues and exclude air, *i.e.*, oils, lard, vaseline sterilized by heat, saturated solution of bicarbonate of soda. Where large surfaces are burned and in burns of the third degree. Thorough cleansing with weak bichloride solution and dressed with some non-poisonous germicide or the wound covered with protective outside of which a bichloride dressing may be used.

One of the best dressings is 10 per cent. carbolic acid in olive oil. This dressing is notably antiseptic and excludes air, and has marked anodyne effects.

After the slough has separated, dress with such dressings as will promote granulation—Zn. oxidi, aristol, iodoform and boric acid. As granulations are fungous and difficult to control, free use of the scissors or nitrate of silver should be employed. Thiersch skin-grafting is more often called for in burns than any other class of wounds.

When large surfaces on the abdomen are burned it is difficult to get skin grafts to take, owing to the respiratory movements. In such burns the granulations will heap up and retard healing, so that we are greatly perplexed for a remedy.

A most satisfactory dressing will be found in sub. iodide of bismuth and 5 per cent. solution of balsam Peru in olive oil. The dressing is applied in the following manner: Dust the wound with the powder, then with a brush spread a thin layer of balsam on a piece of gauze large enough to cover the wound, and upon the whole place a piece of rubber protective. I have seen wounds of the abdomen which had been repeatedly cauterized never require such treatment after the use of this dressing. At subsequent dressings the wound is cleaned with ether to dissolve the oil.

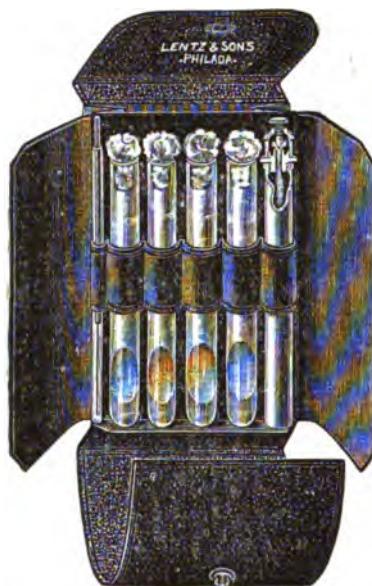
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#### BACTERIOLOGICAL TEST-CASE.

BY CARL V. VISCHER, M.D., PHILADELPHIA.

PROBABLY many who have felt the desire of making cultivation at the bedside, or particularly at the operating table, have been deterred from so doing by reason of the inconvenience of carrying the necessary apparatus, either in the pocket or operating bag. Realizing the growing importance of making primary inoculations in many diseases, not alone for purely experimental reasons, but also for diagnostic and therapeutic ones, it occurred to me to have made a small case as herewith illustrated, containing media, needle and lamp in a convenient form, to be either taken in the pocket or operating bag, with which, in a very few moments, an inoculation can be made. Hoping that, having requisites handy will not only fill a long-felt want of those desiring to make inoculations, but also stimulate many who, with less convenient facilities, would allow

opportunities to pass by default; thus helping to aid in the



advancement of what is probably the most important adjuvant to the healing art—bacteriology.

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#### ANOTHER CURE FOR TUBERCULOSIS OF THE LUNGS.

BY FRANK H. PRITCHARD, M.D., WEAVER'S CORNERS, O.

Koch's tuberculin has come, seen and been conquered. Dr. C. Edson's pilocarpine phenyl treatment is now before the medical and general public in a modest way, the hydrofluoric acid treatment has had its day, the Bergeron rectal gas treatment has vanished into thin gas, with the aniline inhalation method of the Russian professor with a long name ending in "sky." I have discovered a method of attacking this foe of the human race which is too good to hug to my own heart and keep.

The German peasants were, in former days, great believers in exorcism or incantation in the treatment of disease. They called it when practised by some wise old fogey—mudry muz—

as the wends call it—to brauchen. The German verb *brauchen* signifies primarily, to use, to need, etc., and similar meanings; secondarily, the peasants give the meaning of treatment by incantation. This custom was brought to America by the ancestors of the Pennsylvania Germans and the curative methods of the American medicine man or the American Indians resembling those of the Fatherland, the term was christened pow-wowning. This was, undoubtedly, the probable origin of the word. The Pennsylvania Germans, of my neighborhood at least, are firm believers in pow-wowning. They pow-wow for a great number of diseases, as erysipelas, the wasting away—marasmus—of infants, burns, consumption, etc. The old people are those who hold most to the old belief, but among the younger generation there are those who believe in it.

This method of treating pulmonary tuberculosis was communicated to me by a patient who is himself a pow-wower, he having learned it from his aunt. Though I myself cannot use it, for he could not teach me it so that I might gain any advantage from it, as it must be learned from one of the opposite sex, so the tradition runs. I have been taught to pow-wow for burns and erysipelas by a regulation female pow-wower, so that I am in full possession of curative powers against those conditions, though I never have made any use of them.

To return to our muttons, the method consists in a treatment with remedies and with exorcism and wearing of protective and curative charms which are not charming. Firstly, the patient is put under the influence of a cough syrup of vinegar in which two eggs have been dissolved, and to which brown sugar has been added. After his system is impregnated sufficiently with this medicament he is fed upon a powder made by evaporating milk to dryness, and pulverizing the residue. These are supposed to strengthen the system and to build up the low nutritive powers. But as to the real curative method one should proceed as follows: Go out into the back yard or the woods and turn over an old board or an old log and capture three sow-bugs, those active "critters" of a blackish-gray color which dwell under old wood-piles and "sich." These are imprisoned in the shell of an English walnut, this wound with string and tied to string which is suspended around the neck so that it hangs at a level with the pit of the stomach.

These are allowed to hang there for twenty-four hours; they are then removed and hung on again the third day. On the fifth and the seventh days they are again used, the last time, being permitted to hang on the neck for three days. At the end of the ninth day one should go to a running stream, take the bugs in the right hand, standing with one's back to the water course and closing the eyes, throw the shell and bugs into the stream, repeating the words: Father, Son and Holy Ghost, following with the Lord's Prayer or the Creed.

But in order to prevent any disappointment one might employ the following diagnostic measure to detect the disease before subjecting the patient to treatment: Take an egg and wind it with a string made from flax which has never gotten wet and pulling; then put the egg into hot ashes and bake it. If the string burn, then the subject has not the consumption; if it burn, it has.

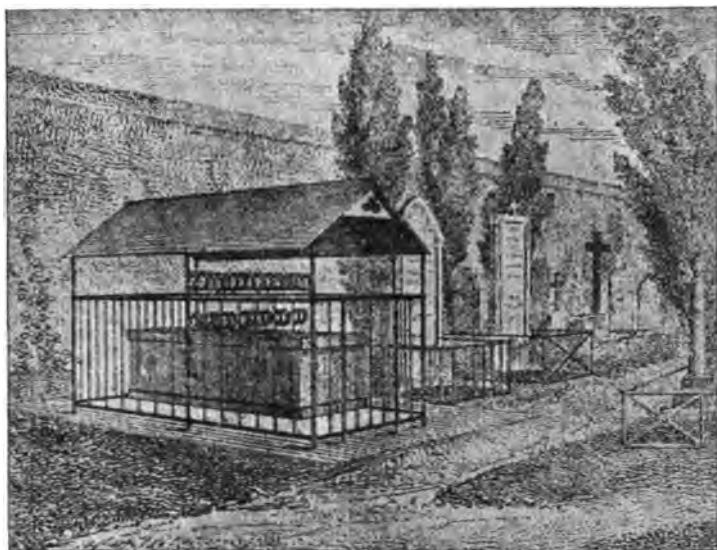
As I said before, I have discovered this cure, and I publish it to the world, but I shall not stand godfather to it. If any one wants to try it he is welcome to any benefit derived from it. Instead of worrying along with dirty sputum to detect the suspected disease and straining one's ear to get the rough and tubular breathing, any one can scare up an egg and a flaxen string. This diagnostic measure is easy, simple, and a child can run it, to use a machine agent's phrase.

Bugs are plenty and walnuts are cheap.

Without a doubt, a number of similar curious and superstitious cures for phthisis might be found in the old medical works if one only had them at hand. Paracelsus's works contain such methods of treatment. Brown-Sequard's testicular juice was foreshadowed by him, for he recommends the testicles of red bulls and stallions as remedies.

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TREATMENT OF CANCER BY INJECTION OF ARSENIC INTO THE NEOPLASM.—Hue (Rouen) has tried interstitial injections of arsenic into inoperable cancers, employing at first a 1 per cent. solution of arsenious acid, and later, the following: arsenious acid, 0.20; muriate cocaine, 1.0; boiled distilled water, 100.0. At intervals of one to six days one or two hypodermic syringefuls of this latter solution are injected into the growth. In a case of epithelioma of the cheek which had recurred after operation with enlargement of the glands, daily injections, continued for several months brought about a complete cure. During treatment, however, the patient had two attacks of erysipelas. A case of cancer of the breast was also cured thus. Of several cases of recurring cancer, some were ameliorated while others were unaffected.—*La S. maine Médicale.*



HAHNEMANN'S GRAVE.

## HAHNEMANNIANA, NO. 6. THE TRUE STORY OF HAHNEMANN'S GRAVE.

BY THOMAS LINDSLEY BRADFORD, M.D., PHILADELPHIA.

SOME time last winter it was decided by the editors of the *HAHNEMANNIAN MONTHLY* that it would be fitting in this year, which is the centennial of the year in which Hahnemann first made known to the world his newly discovered law of *Similia*, to publish in that journal a series of short illustrated articles about the home life of Hahnemann, and I was requested to prepare them. This I consented to do, and we published such a series. The illustrations were as follows: The birthplace at Meissen; the house at Coethen; a photogravure of the large bronze bust now in the Hahnemann Medical College library, and which was sent by Madame Hahnemann to the American Institute of Homœopathy in 1876; a portrait of the first wife; a portrait of the second wife; and it was intended to finish the series with a picture of the tomb of the Master in the Montmartre Cemetery at Paris. Each of the illustrations was accompanied by a short sketch. It was known that Hahnemann's body was buried in the Montmartre Cemetery, that is

by people who knew anything about the matter; I even had a woodcut of the grave which had been published in Schwabe's *Homöopathischer Kalender* for 1892. But I was not quite sure if the picture was a correct one, and before reproducing it in the *HAHNEMANNIAN* I wished to be certain it was correct. Mr. Charles Platt, Professor of Chemistry in the Hahnemann Medical College, was just about to sail for Paris, and I gave him a copy of the picture, with directions as to the location of the grave, and later, at his request, forwarded him the following data in proof that Hahnemann really died and was buried in Paris:

In 1843 the French physician Jahr, writing to the *Allg. hom. Zeitung*, announces that Hahnemann is dead, and goes on to say that he was called to the house by Madame Hahnemann, and saw him lying cold and stiff on his bed (see *Allg. hom. Zeitung*, vol. xxiv., p. 237, Bradford's *Life of Hahnemann*, p. 417).

Dr. Suss-Hahnemann, writing to the *British Journal of Homœopathy*, May 30, 1865, says: "Unfortunately I was only present at the very last moments of my grandfather, not even on the eve of his death, although my late mother and I had arrived in Paris already a week previous to this sad event." This does away with the story that he died at Nice. An account of his death appears in the *British Journal* for October, 1848, as follows: "Samuel Hahnemann died in his 89th year at the house in the Rue de Milan, at five in the morning, after an illness of six weeks. His remains are at present laid in Madame Hahnemann's family vault at Montmartre, but will probably ere long be transferred to Germany."

In 1878 Dr. Gailliard, writing in the French journal *L'Homœopathe Militante*, says: "Where are buried the last mortal remains of the founder of homœopathy? At Paris, it is thought, but all the world is ignorant in what cemetery. One of my confrères in Paris assured me, fourteen years ago, that the body of Hahnemann had been temporarily laid in the tomb of the celebrated painter Lethière.

"At the meeting of August 14th of the last International Homœopathic Congress at Paris, Dr. Van der Heuvel, of Antwerp, presented in the name of the Belgian Homœopathic Society a motion to erect a monument upon the tomb of the founder

of the homœopathic school. The president, L. Simon, then said that the place of burial was unknown. Dr. Petit, allied to the family of Hahnemann, certified, on the contrary, at that same meeting, that the ashes of the Master reposed in the same place where Madame Hahnemann had placed them, but he could not specify it exactly. But little more was said.

"The *Bulletin de la Société Medicale Homœopathique* of France and the *Art Medical* of Paris, for October, announced, over the signature of the pharmacist Ch. Catellan, that Hahnemann reposed in the cemetery of Pere La Chaise.

"I have sought to decide the question beyond all doubt. I addressed myself to the municipal authorities, and received the following official note :

"'M. Hahnemann, Chretien-Frederic, died the 2d July, 1843, Rue de Helder, No. 11, has been buried, the third of the same month, in the Cemetery of the North (Montmartre) 16. D, 1 Ligne—along by the wall No. 9.

"'Madame Hahnemann, his widow, died May 29, 1878, has been buried in the same place.' It is a concession to perpetuity that there is neither cross nor surroundings, only some flowers that have been there for some months. To homeopaths now it remains to do something.—DR. GALLIARD."\*

Dr. Puhlmann, in the *Leipziger Populaire Zeitschrift für Homöopathie*, for July, 1893, says : "As early as six o'clock in the morning, in gloom and rain, on July 11, 1843, a funeral procession moved through the streets of Paris to the cemetery of Montmartre. \* \* \* \* A monumental stone with the inscription : Chretien Frederic Samuel Hahnemann, on the left side of Section 16, of Montmartre Cemetery, marks the spot where the deceased was laid in his eternal resting place. This resting place, as well as those of many other celebrated men buried in Montmartre, as, for instance, that of the poet Heinrich Heine, belongs to those historic sepulchres that are kept in order at the expense of the government, when relatives no longer care for their departed."

The *Homœopathic World*, v. 18, p. 349, says : "Early one morning in July, 1843, a common hearse drew up in the courtyard of Hahnemann's mansion ; the coffin was quickly lifted

\* *L'Homœopathie Militante*, October, 1878, vol. i., p. 456.  
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into it; as quickly the hearse drove away again. His wife, his daughter, his grandson (Suss-Hahnemann) and a young Dr. Lethière, were the only mourners who followed the hearse, on foot, to the neighboring cemetery of Montmartre. There Hahnemann's coffin was pushed in a most unseemly manner into an old vault, where two coffins had already been placed by Madame Hahnemann. There was no funeral ceremony whatever; no funeral rites; no blessing of the distinguished dead." (Probably written by Suss-Hahnemann, see Bradford's *Life*, p. 424.) Suss-Hahnemann, writing over his own name in the *British Journal*, vol. 22, p. 679, says: "The coffin was deposited and is still at the present moment, in an old vault where his devoted wife had already deposited the remains of two aged friends."

In Schwabe's *Kalender*, in which the picture is published, is the following: "The grave of Samuel Hahnemann is at Paris, at the Cemetery Montmartre, and was erected by his second wife, Melanie, whose maiden name was d'Herville Gohier. The monument bears the inscription: Chretien Frederic Samuel Hahnemann. It is one of the so-called historical graves there, which are preserved at the expense of the government when relatives will no longer care for them. Not far from this grave in the 16th department of the Cemetery Montmartre, to the left side, there is the monument of a not less celebrated German, who died in Paris, that of the poet Heinrich Heine."

Dr. Alexander Villers, of Dresden, writing to me in 1893, says: "Frau von Bœnninghausen lives at Münster, Germany, but I think it is not worth while to write to this lady, who is decidedly unfavorable to every suggestion concerning her step-father Hahnemann. I have tried in vain to get from her the permission to put Hahnemann's name on his burial place. She declined in a very unkind way, so that now it is rather a difficult thing to find out where Hahnemann lies."

I received the following letter from Prof. Platt in May: "This afternoon I consecrated to the memory of Hahnemann, beginning with a visit to the cemetery. I enclose a certificate of inhumation (undated), which you will see corresponds with the direction which you gave me; an examination of the facts, however, shows this to be false. No. 9, 16 division, is the grave of Hahnemann's widow, and bears the following inscription: 'Marie Melanie d'Herville, Vve. de Chretien Frederic

Samuel Hahnemann, née le 2 Fevrier 1800, deceđé le 27 Mai 1878. Maman—amour—toujours.' The inscription is much worn. A number of wreaths are placed upon the tomb. The grave of Hahnemann himself is No. 8 of the same line, has no inscription whatever, other than the following letters and figures at the base: 'C. P. 324—411—1832—1834.' This plot is entered in the books of the cemetery in the name of Lethière, but an investigation of the books of that date showed this to be the true resting place of Hahnemann. Your small photograph\* is a true representation of the tomb, and this is fortunate, as I have not been able to obtain a photograph, and an attempt to sketch it for you resulted in a threat of arrest unless I destroyed the sketch on the spot. It is against the law to make any sketches in the cemetery. The tomb is covered with a rusty tin roof, badly broken in places, surrounded by a rusty iron railing, enclosing a few weeds and the inscriptionless tomb. On the cross-bar hang six black wreaths, formerly yellow, probably those visible in your photograph. I discovered an interesting fact regarding the grave, and that is that the present tomb occupies more space than has ever been paid for; that 110 francs is still owing to the city of Paris, and that they will shortly tear up the tomb unless this is paid. It so happened that while I was in the office of the cemetery, I heard the order to that effect. Every effort has been made by the authorities to find some one to pay this account, but for the past year or so they have lost track of all parties concerned. Now, here is a chance for some of the Philadelphia societies to distinguish themselves; 110 francs (\$22.00) to save Hahnemann from being disinterred! Or to go a little further, I find that 110 francs, in addition, will put a new railing around the tomb and a new roof overhead. Thirty francs per year will maintain the tomb in perfect condition. Here there is an outlay of 220 francs (\$44.00) and 30 francs (\$6.00) per year afterwards. Is not the result worth this much? Of course, I presume there will be a few francs in fees necessary, but the present outlay would certainly not exceed \$50.00.

"Now as to the houses where Hahnemann lived. No. 11 Rue de Helder is the Hotel Richmond, where, I am told, Hah-

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\* The picture published with this is from this photograph.

nemann lived shortly before his death. As I understand the proprietaire, Hahnemann did not die in the house, but at Nice. The hotel is first-class and in excellent condition. No. 1 Rue de Milan is on a small street leading off, I believe, from the Rue d'Amsterdam, and in the vicinity of the Gare St. Lazare (Gare de l'Ouest)."

This letter from Prof. Platt was received at Hahnemann College, and before I went home I visited Dr. Raue. He was very indignant that such a thing could be, that while a grand monument was being raised to the memory of Hahnemann his grave should be in such a condition; it was the last time I ever saw him, and I shall not soon forget the interview. From there I went to the home of Prof. Pemberton Dudley, Dean of the College, and told him of the circumstances. He said that Hahnemann College must pay the debt and secure the bones of the master from desecration. And Profs. Dudley, Mohr, and Goodno, meeting at the college, decided to assume the responsibility, and authorized Prof. Mohr to write to Prof. Platt to use his judgment and to take such measures as he deemed fitting to care for the neglected tomb. I wrote to Prof. Platt as follows: "I have seen Prof. Dudley this afternoon and he tells me that Hahnemann College will write, through Prof. Mohr, giving you *carte blanche*. I have explained it all to Prof. Dudley, and we wish you to act as you think best. If the body of Hahnemann is in this grave and can be protected we wish to do so and at once. To my mind there is no doubt that Hahnemann's bones do lie there. Dr. Lethière was a young man who affected homœopathy and who attended Hahnemann in his last illness, and who was one of the four who followed him to the grave."

The next letter from Prof. Platt is dated May 22d, and is as follows: "Just a word to-day to tell you that I have called on several of the French physicians, but apparently they do not know as much about Hahnemann's residences or life here as I do. Knew nothing about Rue de Helder or Rue de Milan, and *did not know he was buried at Montmartre*. No. 1 Rue de Milan is the Hotel de Rouen, a third-class hotel on the corner of the Rue de Milan and Rue de Clichy. The ground floor is occupied by a taxidermist, and carries the sign of *Histoire Naturelle*. The street itself is on the hill above the Gare St. Lazare, and

runs from Rue d'Amsterdam to Rue Clichy; many of the houses are first-class, as, for instance, No. 3, next to the Hotel de Rouen. During Hahnemann's life this building was known as the Hotel Hahnemann; at that time there was no opening on the Rue de Clichy, the entrance being through a garden now belonging to No. 3."

I had given Prof. Platt a letter of introduction to Dr. R. E. Dudgeon, and had also suggested to him that he visit Dr. Suss-Hahnemann in London. He wrote to him, and in a letter dated June 24th, gives Dr. Suss-Hahnemann's account of his grandfather's funeral. The following is a verbatim copy of Dr. Suss-Hahnemann's letter:

"14 Highbury Crescent, London, 21 June, 1896.

"Dear Sir, Dr. Dudgeon has sent me your letter to him inquiring which is the tomb where my grandfather is buried. I am most willing to give you all the information, as I was present at the funeral. My grandfather had the poorest and meanest funeral; he was buried very early in the morning, unfortunately it was raining all the time. Whilst the undertaker-men were carrying the coffin down the staircase of the hotel in the Rue Milan there occurred already a very serious altercation between Madame Hahnemann and the men; for they had put down the heavy coffin too quick on one of the steps and Mme. Hahnemann feared, not that the coffin would be injured, but that the staircase might be damaged, expressing thus more anxiety for the staircase than for the coffin. We all walked behind the funeral car, a very poor affair, to the Cimetière Montmartre. Arrived at the open grave, there was another disturbance. It was an old brick grave with two coffins already in it. I ascertained that one coffin contained the body of a M. Gohier and the other the body of a M. Lethière. My grandfather's coffin being too large would not go into the grave; the men tried for some time to push it into it; at last they were obliged to tear off the top coping stone and thus at last poor Hahnemann came to rest and peace. The grave is that of No. 8, and if it could be opened my grandfather's coffin would be found to be on the top just above the coffin of M. Lethière. It was a very sorry affair, the burial of my grandfather. Mme. Hahnemann had obtained permission to keep the body above ground for a fortnight as she had embalmed the body, at which

operation I was also present. Thanking you for the great interest you take in this affair I remain, yours sincerely,

S. HAHNEMANN, M.D."

The following is Prof. Platt's own account of his experiences in rescuing Hahnemann's grave from desecration: "Armed with a location [16 D, Line 1, No. 9] and with a picture of the supposed tomb, both provided by Dr. T. L. Bradford, of Philadelphia, I visited the cemetery of Montmartre on May 15th. Having traced out the grave according to direction, it was discovered that the location above given did not correspond with the picture, the latter being a reproduction of No. 8, not No. 9. Inquiry at the office of the cemetery at first confirmed No. 9 as the true Hahnemann plot, but further investigation, both at the grave and in the office, showed that No. 9, containing the body of Madame Hahnemann, had been purchased subsequently to Hahnemann's death. No. 8 was entered in the cemetery books in the name of Lethière, the original purchase dating from 1832. The fact that Madame Hahnemann had known Lethière, and that young Dr. Lethière had been one of the few to attend Hahnemann's funeral, led me to the belief that possibly No. 8 was the true resting-place of Hahnemann—a supposition afterwards confirmed.

"During the prosecution of the inquiries at the office, I overheard an order for the destruction of No. 8. I was told that this plot had never been completely paid for, and that the tomb was now to be removed. Believing, as I did, that it was the tomb of Hahnemann, I obtained a delay in the proceedings until the Hahnemann College of Philadelphia could be communicated with and the state of affairs presented to the faculty. Upon return mail, authorization was sent to me by the Registrar, Prof. Charles Mohr, in the name of the faculty, to do whatever I might consider best in the matter.

"The cemetery authorities had at first given me the impression that they possessed an entry of Hahnemann's burial in No. 8; but this I now found to be premature, as they had not, at that time, discovered any record to that effect. For the moment, therefore, further inquiry was abandoned, but having, in the meantime, communicated with Dr. Bradford, I received a few weeks later a complete statement of the facts, so far as known, relating to Hahnemann's burial. With the great assistance

thus afforded, the cemetery was again visited, and a thorough search of the records made. On the certificate of inhumation of Lethière was found a note in red ink, across one corner, referring to an interment on the 11th of July, 1843; and finally, in one of the old books of the cemetery, an entry was discovered recording the burial of Chretien Frederic Samuel Hahnemann, age 89, on July 11, 1843. The one link still lacking in the chain of proof was supplied by the receipt of an interesting letter (quoted elsewhere) from Dr. Suss-Hahnemann, of London. Present at his grandfather's death and burial, his certification of No. 8, the Lethière plot, as the true one, left no further room for doubt. Steps were at once taken to free the tomb from debt to the city. With my wife as interpreter, papers were obtained from the cemetery authorities, were filed at the Hotel de Ville, payment was then made for the plot, and the receipts finally registered at the offices of the cemetery. At the same time orders were given for the repair of the tomb, for the removal of the dilapidated roof of zinc, for the polishing of the stone, and for the repair and painting of the surrounding railing. I was obliged to leave Paris on June 26th, before these alterations could be finished, but Dr. François Cartier, to whom I had the pleasure of showing the tomb on June 25th, kindly offered to see that all was properly executed; and I have since been informed by him of the successful completion of the work."

The following official document has recently been received by Prof. Platt from the Prefecture at Paris, and has been filed in the archives of Hahnemann Medical College of Philadelphia:

"Direction des Affaires Municipales. Bureau des Inhumations. Cimetière du Nord. Addition du °. m. 22 cent. à une concession perpetuelle de trois metre. Republique Francaise. Liberté, Egalité, Fraternité, Préfecture de la Seine.\* Le Pre-

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\* THE PREFECT OF THE SEINE.—In accordance with the decree of the 23 Prairial, year XII., on Sepultures; In accordance with the articles of concession dated April 23, 1842, and Sept. 2<sup>nd</sup>, 1844, establishing that there has been made to Mme Vve Guillon-Lethière a concession of three surface metres of land in the Cemetery of the North;

In accordance with the report of the Conservator of the Cemetery of the North, by which it appears that in the course of the monumental construction undertaken in said cemetery the above concession, in place of the three surface metres conceded, occupies a surface of three metres 22 centimetres, making an excess of 0 metres 22 centimetres the price of which, one hundred and ten francs according to the tarif then in operation, has not been paid;

fet de la Seine, Vu le décret du 23 prairial an XII sur les sépultures ;

“ Vu les bons de concession en date des 23 Avril 1832 et 20 Sept. 1834. établissant qu'il a été fait à Mme. Vve. Guillon-Lethiere concession de trois mètres superficiels de terrain dans le Cimetière du Nord ;

“ Vu le rapport de M. le Conservateur du Cimetière du Nord duquel il appert qu'à la suite des opérations cadastrales exécutées dans le dit Cimetière, il a été reconnu que la concession ci-dessus, au lieu des trois mètres superficiels concédés, occupait une surface de trois mètres 22 cent'rs faisant ressortir une anticipation de 0<sup>m</sup> 22 centièmes dont le prix, soit cent dix francs, au tarif alors en vigueur, n'avait pas été acquitté ;

“ Vu le récépissé délivré par le Receveur Municipal le 25 Juin 1896, duquel il appert que M. Charles Platt agissant au nom des ayants droit de Mme. Vve. Guillon-Lethière a versé à la Caisse Municipale, aux fins ci-dessus, une somme de cent dix francs ainsi repartie.

Part revenant à la Ville de Paris, . . . . .	88f.
Part revenant à l'Assistance publique, . . . . .	22f. —
Total égal, . . . . .	110f.

*Arrete.*

“ ART. 1. Il est fait concession aux ayants droit de Mme. Vve. Guillon-Lethiere, représentés par M. Charles Platt de 0<sup>m</sup> 22 Ces. de terrain dans le Cimetière du Nord par addition aux trois Mètres concédés les 23 Avril 1832 et 20 Sept. 1834.

In accordance with the receipts given by the Receiver Municipal on the 25th of June, 1896, by which it appears that M. Charles Platt, acting in the name of those having the rights of Mme Vve. Guillon-Lethière, has paid to the Municipal Bureau, for the purpose above mentioned the sum of one hundred and ten francs, divided as follows :

Part reverting to the City of Paris, . . . . .	88 francs.
Part reverting to the Public Works, . . . . .	22 “

Total, . . . . . 110 francs.

Be it decreed :

ART. 1. Concession is hereby made to those having the rights of Mme Vve. Guillon-Lethière, represented by Charles Platt, of 0 metres, 22 centimetres of land in the Cemetery of the North, in addition to the three metres conceded April 23, 1832, and Sept. 20, 1834.

ART. 2. The land so conceded is never to be exchanged by sale and is not transferable except by inheritance, by division, or by gift between relatives.

ART. 3. The expenses of stamp and of registration of the present decree, namely 9 francs 60 (3 f. 60 for the stamp and 6 f. for registration), are paid by M. Charles Platt.

ART. 4. Copies of the present decree will be sent :

1st, to M. Charles Platt, chemist of the Hahnemann College, Philadelphia, U. S. A., in the name of legal representative of Mme Vve. Guillon-Lethière.

2d, to the Director of the Administration of Public Works.

3d, to the Conservator of the Cemetery of the North.

Done at Paris the 11th of July 1896, for the Prefect of the Seine, Counsellor of the Prefecture by Appointment. Signed : Laty.

"ART. 2. Les terrains ainsi concédés ne pourront jamais être vendus dans le commerce et ne sont transmissibles que par voie de succession ou partage ou de donation entre parents.

"ART. 3. Les frais de timbre et d'enregistrement du présent arrêté, montant à la somme de 9f. 60c. (soit 3f. 60c. de timbre et six francs d'enregistrement) sont à la charge de M. Charles Platt.

"ART. 4. Ampliation du présent arrêté sera addressée;

"1. à M. Charles Platt, Chimiste au Collège de Hahnemann à Philadelphia (E. U.) au nom des ayants Droit de Mme Vve Guillot-Lethicier.

"2. à M. le Directeur de l'Administration de l'Assistance publique;

"3. à M. le Conservateur du Cimetière du Nord.

Fait à Paris le 11 Juillet 1896. Pour le Préfet de la Seine, Le Conseiller de Préfecture délégué. Signé Laty.

Pour ampliation; Pour le Secrétaire Général le Conseiller de Préfecture Délégué. Enregistré à Paris, Bureau des Actes Administratifs le vingt trois juillet 1896 fs, 5.79. Réçu six francs décimes compris signé illisible."

Hahnemann's tomb has been put in repair and Prof. Platt holds receipts from the marble-worker who made the repairs. It may be mentioned that the receipt given by the Municipality of Paris for the payment of 119 f. 60 is made out: "*Received of Charles Platt for the Hahnemann College of Philadelphia, the sum of 119 francs, 60 centimes for a concession in perpetuity in the Cemetery of the North.*" The picture at the head of this article is a faithful representation of the tomb previous to the late repairs. At present the top has been removed and the tomb left open to the sunshine and the air. It has been given as a legal opinion, that Prof. Platt by the payments made, has really bought the plot in which Hahnemann's body rests, and that as he was acting for the College, Hahnemann College to-day owns the tomb of Hahnemann. In any case it is doubtful if any one can now disturb the body.

And now let us remember that to Prof. Charles Platt is due a very great amount of gratitude, inasmuch as he has roused interest in the neglected grave on the hill at Montmartre, and removed the danger of future interference with the remains of one of the greatest of human benefactors.

## EDITORIAL.

### STATE PRELIMINARY EXAMINATIONS.

WE have before us a copy of the "Rules adopted by the Medical Council of Pennsylvania as to the Preliminary Requirements of those who expect to practice medicine in this State," and within us, an earnest prayer that we may be granted patience to consider it more calmly and dispassionately than it deserves.

These requirements "shall be in operation on and after the first day of March, 1900." They demand preliminary examinations in arithmetic, grammar, geography, orthography, American history and English composition, or in lieu thereof, "the diploma of a college; diploma of an academy, seminary, normal school or high school; or a teachers' permanent certificate; a teachers' provisional certificate (with general average of not less than two); or a students' certificate of examination for admission to the freshman class in a college."

The examinations, when necessary, are to be held on August 21, 1896, at various places in the State, and are to be "in charge of the City Superintendents of the Public Schools, or their assistants, in the various cities named."

We boldly challenge the right of the Medical Council to take such action under the act whereby it was established.

If these rules mean anything, it is that in the year of our Lord 1900, those who present themselves for a license to practice medicine must, at the same time, present documentary evidence that in the year 1896 they were fitted to *undertake the study* of medicine, in addition to the diploma from some *legally* incorporated medical college certifying that they have *successfully completed* their studies! (Possess thyself in patience, oh, my soul.)

In the first place, common sense (not legislative) would require that each institution should be regarded as the best judge of the fitness of those desiring to pursue the course of study offered by it. Here such fitness is to be judged of by a number of entirely irresponsible persons, who cannot be expected to have any practical knowledge of the kind of education neces-

sary to fit a student for the study of medicine. The power to examine and pass on the fitness is granted absolutely; there is no control of the results, no redress and no appeal from their decision. (Our prayer for patience becomes more earnest.)

In the second place, the assumption of the right to decide upon the fitness of a person to *study* medicine is beyond the jurisdiction of the Council, and is unwarranted by anything in the act which called it into existence. This was "to provide for the examination and licensing of *practitioners* of medicine and surgery, and to further regulate the *practice* of medicine and surgery." In Section 5 it expressly states that the Council "shall have no power, duty or function except such powers, duties and functions as pertain to the supervision of the examinations of applicants for *license to practice* medicine and surgery, and to the issuing of licenses to such applicants as have successfully passed the *examination of one of the State Boards of Medical Examiners.*"

It is true that in Section 13 the applicant for a license must present satisfactory proof that he has obtained a "competent common school education," but the whole tenor of the act, as above quoted, is against the supposition that anything was intended but final examinations as to fitness to *practice* medicine.

A "competent common school education" is far too indefinite a term to be intrusted for its explanation to the notions of any body of men in so important an act as the one under consideration—apart from the whole acknowledged purpose of the act.

Information is vouchsafed us "that the following schedule states the amount of knowledge expected by the Medical Council of those whot ake (*sic!*) its examination," and we are glad to find that it expects of *others* a knowledge of grammar, including the formation of plurals, etc.

Who will deny that it is more important for a student to come to a medical college with some acquaintance with Latin than with a knowledge of "the mode of life of the (original) natives of North America," or an ability "to transform poetry into prose?" (Perhaps, on second thought, we might be inclined to grant the utility of the latter accomplishment at times in his passage through college.)

In a properly conducted final examination all that it is necessary to know about the educational status of a candidate could readily be discovered. It is not the crammed common school facts, the presence of which is to be discovered, but the educated mind, the trained habit of thought. Let the boards go on the hunt for these, if they can, and not trouble themselves with matters which do not concern them, and the meddling with which only tends to lessen whatever respect they may possess in the eyes of prospective practitioners of medicine.

By this action of theirs they leave the medical colleges as oases for the student—between the Devil and the deep sea. The time has passed when any criticism of the medical examination fad was sure to be regarded as antagonism to higher medical education. Our position is well known. We want the highest possible standard, but we wish it to be a growth, and out of the colleges, not unjustly and inconsiderately impressed from without. We therefore urge a united and determined stand against the illegal and illogical encroachments of Medical Councils and Boards of Health not only upon the chartered rights of our colleges, but upon the liberties of individuals. Let our State Societies now begin to have anti-legislation bureaus—of legislation we have had enough, and to spare.

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A CASE OF "BLAEHKROPF."—Dr Karl Frank recently observed a pensioner of the Franco-Prussian war, 53 years of age who, emaciated and with cyanotic lips, complained of stridulous breathing. On examination a goitre of the size of a small apple protruded from the right side of his thyroid gland originating sub sternally. Whenever he would cough there suddenly would protrude from the left side of the suprasternal region and apparently coming from under the sternum, an elastic swelling, varying in size from that of a child's to a man's fist. The tumor was tense and elastic, while before the goitre had a flabby feel; on percussion it was somewhat tympanitic, though on auscultation no sound was audible. The circumference of his neck at the height of the seventh cervical vertebra in the undistended state was 37½ cms., while on coughing it would increase to 42½ cms. If one press upon the swelling or the patient cease straining the tumor would disappear as suddenly as it came. The condition was a distensile goitre and not a tracheocele. Diagnostic of the former were the dull tympanitic sound on percussion, the great distension of the subcutaneous veins, the disappearance of the previously palpable goitre which in tracheocele would still present. The filling of the goitre with blood on coughing or straining compressed the trachea and gave rise to the stridor. The examination of the larynx was impossible on account of the patient's having a bronchitis.—*Muenchener Medicinische Wochenschrift*, No. 2, 1896. [Prof. Klausner, *Muenchener Medicinische Wochenschrift*, No. 43, 1895, reports a similar case and dwells on the differential diagnostic features of tracheocele and a distensile goitre. His article is accompanied by several illustrations.—EDS.]

## GLEANINGS.

### GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D., AND FRANK H. PRITCHARD, M.D.

**SEVERE PULMONARY SYMPTOMS IN MITRAL STENOSIS DUE TO INDIGESTIBILITY OF MILK.**—Prof. Huchard (Paris) reports an interesting case of a woman of 51 years who, with a mitral stenosis of rheumatic origin, entered the hospital with her heart disease almost latent, functionally; her heart beat calmly with a regular and almost normal pulse, no dyspnoea nor peripheral oedema. As she had complained for a long time of eructations of gas and sour liquids, nocturnal gastric pains, nausea and vomiting a milk diet was prescribed. Soon symptoms of gastric intolerance set in which were associated with grave symptoms of circulatory disturbance; actual delirium cordis, a small and thread-like pulse, intense dyspnoea, almost violent cyanosis of the lips, cold extremities, expectoration of mucus slightly tinged with blood and a focus of rales subcrepitating at the middle part of the left lung; all pointing to an imminent pulmonary infarct. What was the cause of all this? Examination of the gastric chasm revealed in this very nervous woman a great excess of free hydrochloric acid, which caused the milk ingested to coagulate too rapidly in large masses, which could not be dissolved by the digestive juice, thus producing sensations of weight on the stomach, flatulence, nausea and vomiting, with diarrhoeic stools. These disturbances acting reflexly upon the pulmonary circulation caused a vaso-constriction of the pulmonary blood-vessels, with consequent dilation of the right ventricle and possibly a resulting pulmonary infarct. The right side of the heart is usually dilated in mitral stenosis, and these reflex complications only serve to increase it. This is proved by the same patient that a year previously, in another hospital, she had suffered from symptoms pointing towards an actual pulmonary infarct from being placed on a milk diet. In mitral stenosis the lesion is in the heart but the defect appears in the lungs. One should not forget one of the most frequent causes of the pulmonary symptoms, the stomach. In this patient cessation of the milk diet, with substitution of well-chopped and cooked meat, soft boiled eggs, purées of vegetables, etc., was followed by a rapid disappearance of the serious symptoms in forty-eight hours. Here treatment was apparently insignificant but the results were great. “To know much is to use but few drugs;” he cites Baglivi, “*Multa scire, opertet, pauca agere.*”

**SCARLATINA INOCULATED THROUGH WOUNDS**—Dr. F. Ingerslev (Copenhagen) has recently observed three cases where scarlatina apparently gained entrance into the system through wounds or burns. They seemed to have been undoubted cases. They were characterized by the characteristic exanthem, the “strawberry” tongue, the angina and finally with desquamation. The pharyngeal symptoms he ascribes to an exanthem of the mucous membrane of the throat. He thinks that this variety of scarlatina is more frequent than is generally observed. He cites Murray, who described a hospital epidemic where in one ward, with twenty-seven patients, six, with solutions of continuity of the skin, contracted scarlatina, while only one, who did not present a wound showed the disease.—*Hospitalstidende*, No. 24, 1896. [Since Sir James Paget in 184 demonstrated that scarlatina is quite frequent in those with open wounds, the literature has offered a number of such cases, though our knowledge on this point is not clear; for it may be simulated by local hyperemias as well as by toxic and septic erythemas.—Eds.]

**A TREATMENT OF ERYSIPelas.**—Dr. Pavlovsky has tried all the local measures recently recommended in erysipelas, and has found that they do not, in the least, influence the morbid process. For a long time he has been in the habit of employing absolute cleanliness by washing the affected parts with soap and water, and he is quite satisfied with his results, for they were certainly as good as with other more energetic local measures.—*Wiener Medizinische Presse*, No. 23, 1896.

**THE IMPORTANCE OF BACTERIOLOGICAL DIAGNOSIS IN CERTAIN DOUBTFUL CASES OF TYPHOID FEVER.**—Dr. G. Singer (Vienna) reports a case of typhoid fever which simulated meningitis. The patient, a trained nurse of 21 years, had been affected with otorrhœa since childhood, and which from 1889 had been complicated by caries of the mastoid, for which she had several times been operated upon. Suddenly she was seized with violent headache, chills, vomiting, and on taking to bed, besides an intense fever, she complained of stiffness of the neck, as well as cutaneous hyperesthesia. These symptoms, together with her history of ear suppuration, led to a suspicion of meningitis; yet the presence of a considerable swelling of the spleen rendered typhoid fever possible. During the first three days of observation she vomited repeatedly; her abdomen was retracted; her lungs were normal. On the fourth day of observation the urine was found to contain a large number of typhoid bacilli. In the following days roseola appeared, and the further course of the disease was that of a mild typhoid. The detection of these micro-organisms prevented an operation, which seemed so called for. In this case the infection was probably transmitted through the urine of another typhoid patient, for she had rinsed the urinals of the typhoid patients.—*La Semaine Médicale*, No. 25, 1896. [Prof. Goodno (*ibid.*) calls attention to the possibility of confounding certain cases of *typhoid fever* with cerebro-spinal fever. The danger lies in not recognizing typhoid cases beginning with delirium, pains in the head, retraction of the neck, high fever, spasm and tremor. Osler (*ibid.*) also directs attention to the difficulty of diagnosing such cases, where a few days must pass before a decision can be made. "Cerebro-spinal meningitis is a rare disease," he says, "and typhoid fever a very common one, and the onset with severe nervous symptoms is by no means infrequent." Fully half the cases of so-called brain fever, he claims, belong to this category. Prof. Goodno then considers, with characteristic thoroughness, the resemblance of tubercular meningitis to typhid. The history is here of diagnostic importance, for such cases will show a scrofulous diathesis or a history of tubercular inheritance. The disease develops gradually; the pulse is usually slow, and the temperature, in the early stage, low; eruptions do not develop; delirium is slight; the muscular rigidities and spasms do not occur until late, and then are not so marked as in cerebro-spinal fever.—Eds.]

**PRIMARY ENLARGEMENT OF THE SPLEEN.**—Dr. S. West (London) relates a case of this rare disease. A man of 36, who a year before had bled profusely after extraction of a tooth, commenced to grow weaker and weaker, with frequent attacks of epistaxis. When seen he was extremely pale and cachectic, and his saliva tinged with blood from his gums. His temperature was 39.5° (C.), his spleen very voluminous and slightly sensitive on pressure; the red corpuscles were decreased in number as well as the haemoglobin in quantity, but the number of leucocytes was only slightly augmented. The other organs seemed normal. Subsequently retinal haemorrhages developed, and in five weeks he was seized with œdema of the glottis, requiring tracheotomy. The tracheal wound oozed constantly; tamponing was powerless to arrest it, and five days after he died, in a few minutes, from penetration of blood into the trachea. The necropsy revealed a hypertrophic liver, weighing 290 grammes, and a spleen of 2280 grammes. This latter organ was soft, slightly cirrhotic and the seat of an infarct. The lymph-glands were not enlarged, nor, as was said, was there leucocytosis, splenomegaly, with rapid, progressive anaemia or pseudo-leucæmia. This disease passes through three distinct periods.

1. Progressive weakness with, possibly, pains in the spleen.
  2. Increase of the splenic pains, in some cases, to intense colic; the spleen increases in size, the weakness aggravates; fever sets in, which may be intense, and haemorrhages from different organs appear, notably from the mouth, nares, stomach or intestine. The blood changes are those of simple, severe anaemia.
  3. Rapidly mortal cachexia.
- The average duration is one year. All ages and both sexes are affected, though adult males are seemingly more liable. The liver and spleen are alone affected of all organs.—*La Semaine Médicale*, No. 31, 1893. [Dr. S. Coupland has reported a case where the spleen was extirpated and a plethoric state with a return of health for two years followed, but a fatal haematemesis put an end to the patient's life.—Eds.]

#### DIABETES, WITH PIGMENTARY CHANGES IN THE SKIN BRONZED DIABETES.—

Dr. Dutournier has studied this rare form of diabetes which Hanot and Chauvillard have succeeded in elaborating out of obscurity.

It is to be regarded as a distinct disease, where the diabetes is the effect and not the cause, and which is dependent upon an unknown change in the blood.

The diagnosis is easily made when the three symptoms, glycosuria, abdominal disturbances, among which cirrhosis of the liver is the principal one, and is due to the melanoderma, and the pigmented skin are present. The absence of glycosuria would exclude the disease. Melanoderma is a prime symptom. Some symptoms might lead one to a diagnosis of cancer of the liver, yet the nodose feel of the organ and the cachexia will exclude bronzed diabetes. In hepatic syphilis the liver is always irregular, nodose and sometimes with a much curved border.

Melanotic sarcoma of the liver may resemble this form of diabetes absolutely. If other symptoms be lacking the reaction of melanemia will, from the test of the urine, be decisive.

Malaria cachexia has many points of resemblance. But here the splenic enlargement is constant and considerable; the color of the skin, dark brown, differs from that of pigmented diabetics, which is leaden gray, almost bluish.

The melanoderma and the muscular weakness might be confounded with Addison's disease, but though the skin pigmentation be different the examination of the urine and the presence of the enlarged liver will exclude Addison's disease.

The prolonged use of arsenic and silver will color the skin also, but the history of the case will exclude these. Pediculi corporis, if inveterate, may give rise to a skin pigmentation. No treatment retards the disease, nor prevents the development of the terrible cachexia. Antidiabetic diet will reduce the quantity of sugar, but otherwise it is inactive. Arsenic, glycerophosphates and cod-liver oil may be tried.—*Rirista Clinica E Terapeutica*, No. 4, 1896. [The rapid emaciation of this disease is terrible, and the cachexia rapid. The face is emaciated, bony; the look vacant and uncertain. Mosse reports a case where the patient only weighed thirty-nine kgms.—Ede.]

**IRRITABLE BLADDER.**—Dr. Peyer considers this affection a neurosis. The chief symptom, vesical tenesmus, appears both during the day and night; there is a spasmodic state of the sphincter, with spastic enuresis and spastic ischuria, burning on urination, pains in the loins, a sense of pressure in the hypogastrum, cold feet, anesthesia or hyperesthesia of the genitals, inability to stand for a time, etc.

In diagnosis, examine the whole patient, his nervous system, thorax, abdomen, kidneys and pelvic organs and then the bladder. Examine the urine for urethral threads, gonorrhœa, or long-lasting masturbation; the prepuce for phimosis, balanitis, smegma; the urethra for irritable or inflamed spots; sound the urethra; examine the post-bulbar portion by the rectum. A diagnosis must be made by exclusion. Differentially, one should exclude:

1. *Acute parenchymatous nephritis*, which is recognized by albuminuria, casts, blood- and pus-corpuscles.

2. *Contracted kidney* presents increased or decreased quantity of urine, rarely casts, albuminuria and hypertrophy of the heart.

3. *Pyelitis* has pus and blood in the urine, with pains in the regions of the kidneys.

4. *Chronic pyelitis* causes the urine to be increased nearly double in quantity, so that this sign is almost pathognomonic. The albumin is greater in quantity than the pyuria would seemingly give rise to.

5. *Diabetes mellitus* and *insipidus*, as well as *retention of urine*, offer no special difficulties.

6. A contracted bladder cannot be filled with over 50 to 100 gms. of urine.

7. *Stone in the bladder* has been often operated for without any stone having been found.

8. *Fissures of the neck of the bladder* are not rarely met with in men, and are sometimes due to a former gonorrhœa. There is great pain after urination, and in the last drops of urine are detected white bodies with red blood-corpuscles. The endoscope will confirm the diagnosis.

9. A beginning stricture or one of large calibre may be gradually accompanied by tenesmus vesicæ and a disagreeable burning in the urethra. The sound is here the decisive measure; any one that will pass the meatus should pass through the whole canal, as the meatus is the narrowest portion. In general, where a No. 20 French bougie will not pass, one may safely say that there is a stricture.—*Norsk Magazin for Lægeridenskaben*, No. 5, 1896.

**MOBILITY OF ABDOMINAL TUMORS.**—Prof. H. Nothnagel (Vienna) states that

mobility in an abdominal tumor may be dependent upon the respiratory movements of the diaphragm, the peristaltic movements of the stomach or intestines, pressure from without or pressure from within (gravity).

The liver, stomach, spleen and, in a measure, the kidneys, are influenced by the respiratory movements of the diaphragm, descending with inspiration and ascending with expiration. The intestines are also occasionally affected by these movements. If the tumor can be held back during expiration, it points rather to a stomach tumor than to one of the liver. The movements of respiration may be lacking from failure of the diaphragm to descend, as in pleuritis or emphysema, or if adhesions have formed so as to fix the growth. Slight differential mobility of a renal growth will sometimes differentiate it from one of retroperitoneal origin. Peristaltic motion of the intestines or stomach, as a rule, influences the position of a tumor but little, though the contrary may be observed. Passive mobility from palpation may be able to restore a dislocated liver with ease to its proper position; the same is true of the spleen or kidney, though these organs may be so fixed by adhesions that the immobility of such a tumor does not exclude a dislocated organ. Intestinal tumors are usually very movable: this is of importance in differentiating a sacculated paratyphilitic exudate from a neoplasm. Tumors of the stomach, and especially pyloric carcinoma, sometimes are quite mobile passively, with but slight respiratory movability. Tumors of the gall-bladder, ovaries, omentum and uterus are occasionally found slightly mobile. Wholly immovable are abcesses, sacculated exudates, aneurisms, tumors of the pancreas, of the retroperitoneal glands, the bones, as well as sarcomata of the undescended testicle. By adhesions the most movable tumor may become immovable.

Tumors moving by gravity are generally those of parts capable of locomotion in themselves, as the stomach or intestines; thus a dilated stomach may force a neoplasm into the lower abdominal region, or an intestinal neoplasm, by stenosis or stagnation of faeces, may give rise to such mobility.—*Wiener Medizinische Presse*, No. 19, 1896. [Dr. W. H. Murray (*Refen. Handbook of the Medical Sciences*, vol. ii., 187) quotes Dr. Watson to the effect that tumors which are readily movable in the abdomen are generally intestinal, omental or ovarian.—Eds.]

**HYSTERIC CONTRACTURE OF THE MASTERS.**—Dr. René Verhogen (Brussels) records the case of a boy of 12 years, who, after a blow on the cheek from a companion, was unable to open his mouth. If told to do so, he would open his lips, and if he persisted he would experience a violent pain in his right masseteric region. By exercise of continuous and gentle force one could open the mouth, yet a series of contractions could be felt in the muscles of the jaw. The sensibility of the skin of his face was normal, if one except a small area at the angle of the jaw; but there was an absence of the thermic sense in the skin of the left arm and shoulder, as well as of a portion of the right forearm. Chloroformization enabled him to exclude a lesion of the temporo-maxillary articulation. With these data and the hereditary hysteria of the child, a diagnosis of hysterical contracture was made, the blow acting merely as a local etiological cause. Treatment by suggestion (non-hypnotic) and the use of a very mild faradic current were successful.—*La Settimana Medica*, No. 17, 1896. [Prof. Charcot, in his *Leçons de Médecine*, has described a similar case, where a woman, who gave her child a blow with her hand, was seized with functional paralysis of that member and complete anesthesia of the skin.—Eds.]

**SLATE-COLORED APPEARANCE OF THE FINGER-NAILS AS A SIGN OF MALARIAL INFECTION.**—Dr. Boisson claims that malaria produces a slate-colored discoloration of the finger nails, which sign he has found of importance in the masked or ill-developed forms of the disease, as well as in other conditions arising in old malarial subjects. This coloration, which is peculiar to the disease, from whatever quarter of the globe it be brought, is noticeable before the chill, increases during it, and reaches its greatest development at the stage of heat, disappearing during the sweating stage. This phenomenon he explains by the destructive influence of the malaria parasite upon the red blood corpuscles. It may mark an abortive attack, or be wanting in febrile seizures of another character in a paludic subject, as, for example, in a croupous pneumonia which began with a chill, in an old malarial subject, but where the "sign de l'ongle" was absent. Finally, in a similar patient with cystitis and intermittent attacks of fever, this sign being present, quinine was administered, and both the fever and the bladder disease disappeared.—*La Semaine Médicale*, No. 25, 1896.

## GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D., AND H. L. NORTHRUP, M.D.

**CALOMEL TREATMENT OF HÆMORRHOIDS.**—Akerblom, acting on the suggestion of Massini, of Basel, has treated a number of cases of hæmorrhoids, large and small, internal and external, with an ointment composed of one part of calomel and nine parts of vaseline, and states that in none of them has he felt obliged to operate. In most cases the itching subsides completely. The suggestion is made that the calomel is changed into corrosive sublimate and acts as a caustic, and consequently should be used with caution if there is ulceration.—*Therap. Wochensch.*

**ADENITIS OF THE NECK AND CARIOUS TEETH.**—Starck draws a practical lesson from his observations on the connection between simple and tuberculous chronic cervical adenitis and carious teeth. With reference to this point, he has examined upward of a hundred children between 3 and 12 years old. Excluding all cases in which any possible cause could be assigned for the glandular swellings, such as an hereditary tuberculous tendency, recent attacks of measles, scarlet fever, diphtheria, or angina and the like, he has found that in 41 per cent. of the children affected with chronic cervical adenitis no other cause could be recognized than dental caries.

Carious teeth, then, are to be set down as among the commonest avenues of infection in children, along with tonsillar tuberculosis. In five cases, of which the histories are given, unilateral tuberculosis of the sub-maxillary glands developed in immediate connection with toothache. In one of these cases, two carious teeth were extracted, and tubercle bacilli came with them. In only one case was the tissue between the roots of the teeth found to be tuberculous.

Starck states from his observations that surgeons should make it a rule, whenever they operate for tuberculous glands of the neck, to extract any carious teeth that may be present, since otherwise they may prove a source of relapse. Moreover, it follows from the importance of carious teeth as points of entrance for infection, especially in children, that endeavors to make adequate care of the teeth and mouth obligatory in schools should have the zealous aid of physicians.—*Centralblatt für Chirurgie.*

**DISLOCATION OF BOTH SHOULDER-JOINTS.**—Haslip was called on June 1st to see a man, aged 41 years, being told by his wife that he had a fit the previous evening and had fallen, and he had been unable to use his arms since. The shoulders and arms were considerably swollen and bruised, and an examination showed a subcoracoid dislocation of both humeri, which were easily reduced by the extension method. Whether one or both were caused by the fit or the fall is, the doctor thinks, purely a question of surmise. There was no previous history of any dislocation.—*The Lancet.*

**THE THERAPEUTIC VALUE OF THE MIXED TOXINS OF THE STREPTOCOCCUS OF ERYSIPELAS AND BACILLUS PRODIGIOSUS IN THE TREATMENT OF INOPERABLE MALIGNANT TUMORS.**—Cooley reports 160 cases of malignant tumors treated by the mixed toxins, in *The American Journal of the Medical Sciences*, goes over the ground covered by him in previous papers, and concludes as follows:

1. The mixed toxins of erysipelas and *B. prodigiosus* exercise an antagonistic and specific influence upon malignant tumors, which influence in a certain proportion of cases may be curative.

2. This influence is slight in most cases of carcinoma (including epithelioma), most marked in sarcoma, but varies with the different types, the spindle-celled form showing by far the greatest influence.

3. The action of the toxins is not merely local in character, but systemic.

4. The toxins should be used only in clearly inoperable cases, or after primary operation to prevent recurrence.

5. The results will vary greatly with the strength of the preparation, the most virulent cultures giving the best results.

DIAGNOSIS OF CHRONIC ABSCESS OF THE BRAIN.—Eskridge reports several cases, comments upon them, and closes his paper as follows:

The only conclusion at which one can arrive after a study of all the symptoms of chronic abscess of the brain is, that the diagnosis is often a most difficult one, and sometimes is an object of impossible attainment. The nearest approach to accuracy in diagnosis in obscure cases is to arrive at a conclusion which amounts to a problematic diagnosis between two or more morbid processes. To recommend an operation for the relief of chronic abscess of the brain only in those cases in which the diagnosis is certain, is to sacrifice many lives that might otherwise be saved by judicious boldness. The physician who has not the courage to recommend an exploratory operation in a strongly probable case of abscess of the brain, lest he may be wrong in his diagnosis, is more solicitous for his own reputation than for the welfare of his patient. If we are ever to reach positiveness and certainty in the diagnosis of obscure brain diseases, it will be attained only by a careful study of minute symptoms and what often seems unnecessary and tedious detail.—*American Journal of the Medical Sciences*.

CATGUT-STERILIZATION.—Hofmeister, after referring to the different methods of catgut-sterilization that have been employed in Braun's clinic at the University of Tubingen, recommends the following process, the value of which depends upon the capability of formalin of acting on lime substances so that they lose their solubility in boiling water:

1. Harden the raw catgut, which has been previously wrapped upon reels, in 4 per cent. solution of formalin for twenty-four hours.

2. Boil in water for ten minutes.

3. Harden again in the formalin solution and preserve in alcohol, to which 5 per cent. glycerine and 1 per cent. sublimate, or other antiseptic in suitable quantity has been added. The strands remain from the beginning of the sterilization on the same reels, so that touching with the fingers may be avoided. It is necessary to wind the catgut before beginning the sterilization, because the loose catgut rings entangle when placed in the solution and in boiling become converted into unravelled balls. When putting the reels into the solution of formalin much care has to be taken to remove the great number of air-bubbles which remain among the strands, so as to have the finished preparation uniformly firm. The tensile strength of the sterilized threads which were examined with a dynamometer compared favorably with the raw catgut.

Bacteriologic investigation showed the prepared catgut to be free from spores.—*Centralblatt für Chirurgie*.

TREATMENT OF COLD ABSCESES.—Gage contributes an article to *The Boston Medical and Surgical Journal* on this subject. We quote his résumé:

1. An abscess occurring in connection with tubercular disease of the bones or joints is always secondary in importance, as well as in development, to the primary disease. Its treatment must not, therefore, in any way interfere with the treatment of the original lesion.

2. When the abscess is accompanied by any evidences of constitutional impairment, or interferes in any way by its location with the use of proper mechanical treatment, it should be immediately opened. When there is no interference with general health or with mechanical treatment, the abscess, if it presents a pure tubercular infection, may be left until it is nearly ready to open spontaneously. If it presents a mixed infection, it is to be opened at once.

3. All cases are to be opened as soon as they approach the surface, to avoid unnecessarily extensive burrowing.

4. Of the methods commonly used in opening these abscesses, aspiration with irrigation, free incision with curetting, all seem to give inferior results to those obtained by simple incision in most dependent portion, with the least possible interference with the walls of the abscess.

SURGICAL HINTS.—Surgical operations put off until too late are of very frequent occurrence. Operations performed too early are so rare that one never hears of them. The lesson is a very plain one—operate in time if you wish to do all in your power to save your patient.

In peritonsillar abscess, an aspirating syringe with a long needle will usually find the pus with very little pain, and will often prevent the repeated blind stabbing so annoying to the surgeon and so demoralizing to the patient.

Never perform an operation without examining the urine for sugar, no matter what its specific gravity may be. If glycosuria exists, antiseptic precautions should be redoubled, but the condition does not contra-indicate necessary surgical interference.

Never examine for crepitus in supposed fracture of the skull. Depression or other unevenness of surface, together with symptoms referable to cerebral injury, will enable one usually to make a diagnosis and will not jeopardize the life of the patient.

An exploratory operation is often of value, but it is very seldom that an operation of any kind is not more or less of the "exploratory" variety. The cleverest diagnostician may err as to important particulars. It is our duty to make every effort to know the disease we are fighting, to discover the enemy's position and estimate his strength before advancing to the attack.

Iodoform is a very useful drug, which nothing has been able to replace; but it must not be forgotten that it may be a local irritant and a systemic poison. Acute constitutional iodoform poisoning occurs much more easily by absorption from fresh wounds than by absorption from granulating surfaces. A quick, small pulse, dilated pupils and slight elevation of temperature, is a combination of symptoms which, occurring within thirty six hours of an operation where iodoform has been used, should lead us to suspect the drug intoxication. Delirium, icterus and a roseolar general eruption make the diagnosis almost certain. At the first symptoms all iodoform should be removed from the wound and the elimination of the poison by diuresis should be encouraged, at the same time nourishing and stimulating the patient. Fortunately, this condition is rare, but when once seen can never be forgotten.—*International Journal of Surgery*.

**THE TREATMENT OF BURNS BY PICRIC ACID.**—Papazoglou recommends, from practical experience, the employment of picric acid in the treatment of burns. He claims that the application of the solution of this acid to the burn does much to relieve pain; that it is antiseptic, and prevents or clears up suppuration; that it favors cicatrization and healing of the skin; and that, if applied immediately after the accident, it prevents, to a great extent, the formation of blebs and cutaneous congestion. Where the burns are very extensive the patient may be immersed in a bath of picric acid; if the lesions are limited, a picric acid solution may be placed upon antiseptic gauze and applied to the part. The following solution is the one employed:

B Powdered picric acid, 75 grains; alcohol, 2 ounces; boiled or distilled water, 1 quart.

These applications are employed for three or four days, rigid antiseptic precautions being continued.

Even in severe burns two or three applications are quite sufficient to produce almost an entire cure.

**EUCAIN.**—Since the introduction of local anaesthesia by means of cocaine, cases have not infrequently been reported in which this drug has produced toxic effects. For this reason, pharmaceutical chemists have endeavored to discover a substitute for cocaine, which, while equally efficient, would be devoid of its injurious action. The outcome of these experiments is eucain, which has already proved to be a powerful and yet practically innocuous anesthetic. In operations upon the eye, a two per cent. solution of eucain hydrochlorate has given excellent results, while in diseases of the nose and throat it has been successfully employed by Reichert. Saalfeld has utilized its anesthetic properties in cutaneous affections, in form of ointments, and Schleich in diseases of mucous membranes. In dental surgery eucain already enjoys a wide popularity, and it promises to replace cocaine as a local anesthetic in general surgical work in the near future.—*International Journal of Surgery*.

**Possible Dangers of Treating Extensive Burns with Boracic Ointment.**—Hall describes a case of extensive burns in a boy treated with unguentum boracis. On the fifth day he developed a severe erythematous eruption over the limbs, trunk and face. During the next few days he gradually became worse and died on the ninth day. At the necropsy nothing was found to account for death, and

previously to the eruption the boy was doing very well. There were no throat symptoms whatever; there was delirium at night; the rash developed more each day.

Hall quotes many recorded cases of similar groups of symptoms occurring definitely from boracic poisoning, and points out that the extent of surface for possible absorption in the above case was very great, and, although not pressing the connection between the boracic acid and the symptoms, thinks that if there was no connection between the two, still the occurrence of such fatal symptoms is worthy of more extended inquiry than is at present given, with a view to preventing their occurrence by a more rigid antiseptic treatment.—*The Lancet.*

## GYNAECOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D.

**THE CURE OF SEPTIC PELVIC DISEASES IN WOMEN** (Fernand Heaton, M.D.).—In all cases where dilatation is necessary, the functions of the cervical ganglia must be so obtruded as to prevent uterine contractions. If necessary to obtain this result, the cervix must be incised. Make a straight cut through the posterior lip, in the median line, to the vaginal junction, the beginning of the incision being well up above the internal os, and growing deeper until it strikes the posterior fornix, the dilatation being continued, however, with care, after the incision, so as not to tear open the posterior cellular spaces too much or open the peritoneal pouch, though such an event will not produce trouble unless irrigation is employed and washes septic material into the general cavity, and, being unnoticed, no drainage is employed. The uterus must be cleansed, and the sharp curette is the most available instrument in our possession. We must use it, even though reckless or clumsy fellows occasionally do harm with it. We cannot always reach and remove all the diseased parts with it, I allow, but it is our best resource, and by using it carefully but thoroughly, we do the best we can. Then wash out with plain water, and mop out as dry as possible by packing in a strip of gauze and withdrawing it. Then cleanse out with peroxide of hydrogen, this being done by soaking a strip of gauze in the peroxide and pushing it lightly in the cornua of the uterus and packing the cavity lightly also, and then withdrawing it. Again introduce the dilator, to make sure of relaxation and good drainage, as well as of escape of gas; pack thoroughly with gauze well saturated and tightly wrung out of a 10 per cent. sterilized emulsion of iodoform in glycerine.

The vagina, in the disinfection of which very great care must be taken before, during and after operation, should be packed with iodoform gauze, and this vaginal gauze pack should be changed in twenty-four to forty-eight hours, and as frequently thereafter as necessary to prevent reinfection; for it is manifestly absurd to dilate, curette and drain the uterus, taking away all dressings in three or four days, and being content with ordering a vaginal douche, and reproducing the disease by vaginal infection, when so much trouble has been taken with the operation.

The day that septic infection has reached beyond the bounds of the uterus, what can we do? According to the general methods prevalent at the present time, there is only one answer. It seems sad to contemplate removing the appendages at the outset of the disease, and yet it appears very, very sad to wait, it may be for months, it may be for years, for nature's cure, with the ever-present shadow of a future mutilating operation.

The writer has proposed a method, surgical though it be, but not involving the removal of any organ, as a first step in the future treatment of these diseases.

*The operation* consists in the simple incision of the posterior vaginal fornix and the drainage of the affected seat of trouble when it is reached.

The explanation of the technique gives a better understanding of the method. An incision is made, following the contour of the posterior face of the cervix, at its vaginal junction, but not going too high at the sides to provoke hemorrhage from the larger vessels. The incision is made by scissors, knife or Paquelin cautery. When the indications point clearly to pus and long drainage, use the cautery, and the edges, being seared, will not show a tendency to contract so quickly. From the centre of this, parallel to the axis of the vagina, another incision is made, of variable length, to give free access. Detach the retro-uterine connective tissue, always working against the posterior uterine surface. The uterus, during the operation, is held steady by moderate downward traction, the posterior or both lips of the cervix being held by a tenaculum. If you can determine the proximity of the peritoneal cavity, detach the tissue first in that direction. This penetration and detachment of the tissues is done with the finger.

If working in dense tissues or infiltrated ones, occasionally withdraw the finger and look closely for the possible appearance of pus. If you have reached the peritoneum and have uncovered no pus, open the general cavity at once. This is very important.

Almost the only source of danger results from neglecting this step. The reason is obvious. The manipulations may cause a leakage into the general cavity of pus from a fragile sac within. Even if you use but little force the traction on the uterus might do it. Pus into the dependent portion of the cavity does no harm if wiped out and drained. Retained pus without bounds will almost certainly kill. Moreover, it is a great advantage to explore the pelvis before doing anything further; therefore, if the cavity is open wash your hands, disinfect the vagina again by placing a gauze sponge in the wound and irrigating, and proceed to explore the pelvis from the inside, passing the volvella on the uterus to your assistant and using the left hand suprapublically, the same as in bimanual examination, bidding the assistant to relax or increase the traction on the cervix as best suits your purpose. If you strike pus before the general cavity is opened you may follow it up, the hand placed above indicating the direction by marking out a mass, and the finger within seeking the way of least resistance and resilient tissue characteristic of exudate. If the finger penetrates a well-defined cavity of pus or sero-pus behind or to the sides of the uterus, and it is evident by bimanual palpation that this constitutes the whole disease, and, to be reasonably sure of this, the result of your examination now, minus the exit of pus, must correspond with the conditions found on examination of the patient while anesthetized just before the operation, and you are quite certain you have not opened the general cavity, you may stop then, and, after introducing drainage and packing the vagina, the patient may be put to bed. If you have any doubts about these points clean off the whole field thoroughly, clean the vagina, clean your hands, put a little pack of gauze into the hole made by your fingers into the abscess, open the cavity of the peritoneum behind, wash the right hand again and introduce one or two fingers again and explore from within. If nothing is found drain Douglas's sac and place a good drain in the abscess cavity and you will be safe. In all cases the operation is to be preceded by thorough and efficient dilating, curetting and packing of the uterus.—*Am. Gyn. and Obst. Journal*, June, 1896.

**GAUZE AS A MATERIAL FOR DRAINAGE** (L. Grant Baldwin, M.D.). **METHOD OF APPLYING.**—A piece of gauze, plain, iodoform, or whatever variety is desired, only being certain that it is sterile, a yard wide and of a length sufficient to extend to the deepest part of the cavity to be drained. This is then twisted as firmly as possible and made to go to the bottom of the cavity without bending up on itself.

The protruding end should be left long enough to make a considerable surface for contact with the dressing outside, and it should not be constricted too tightly at the incision. Gauze used in this manner has so far met the indications for me. If free oozing comes from points that cannot be easily controlled by this one column of gauze, of course more may be packed around it in the usual way.

The dressing on the abdomen should be moist and not allowed to dry, as that will materially interfere with the drain.—*Am. Gynecol. and Obst. Journal*, June, 1896.

## MONTHLY RETROSPECT OF HOMOEOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D.,  
FRANK H. PRITCHARD, M.D., AND F. MORTIMER LAWRENCE, M.D.

**LACHESIS AND LYCOPODIUM IN DIPHTHERIA.**—The most important symptoms are the subjective ones. A very pronounced symptom, and one of the earliest ones, is the great prostration, mental and physical, which is *prima facie* evidence that the nerve centres, the citadel of life, are attacked. Prostration is the initial symptom. It matters not what the disease may develop, the fact that you have this early and great prostration indicates that the disease is violent in its nature, and those remedies which rapidly disorganize the life-force are first to be thought of. Now then, when would *lachesis* be indicated? One of the first questions I ask is, "Upon which side of the throat did the disease begin?" If I find that it began upon the right or the left side, it may narrow the choice down to possibly half a dozen remedies. Why should we select a remedy for a particular side of the body? Because nature begins the manifestation on one side or the other in 75 per cent. of all cases. *Lachesis*, in the development of its symptoms, produces them from left to right, and stands at the head of the list! *lycopodium* from right to left. Whenever you find in diphtheria, follicular tonsillitis, quinsy, etc., that the trouble began on the right side of the throat, *lycopodium* is one of the first remedies to be thought of. Some say *belladonna* and *aconite* in alternation to overcome the fever. This is preposterous; fever is a mere concomitant of the constitutional condition, like the membrane. *Aconite* and *belladonna* are nerve remedies in typical diphtheria; they are not sufficiently deep acting, and are indicated only in sthenic conditions. If the fever runs very high, the trouble on the right side of the throat, violent throbbing headache, great anxiety, restlessness, and intense pain on swallowing, *belladonna* will abort the disease, but it will not be diphtheria. There is not the great prostration in such cases. There may be fever, hyperemia, restlessness and tossing about, but not the great prostration. The diphtheria patient is generally quiet, there may be anxiety, but no violence in the manifestations.

If the disease be of a malignant nature, beginning on the right side, pains in the throat better from warmth, worse from cold, patient generally worse at 4 P.M. (particularly from 4 to 8 P.M.), without the slightest hesitation give *lycopodium* to that patient and it will cure, no matter what you call the disease.

I have said that *lachesis* takes the lead in throat troubles commencing on the left side; the intense sensitiveness about the throat, the great prostration, the aggravation at night, usually before midnight, and after sleep, are all met by *lachesis*, which is still more strongly indicated if there is aggravation from warmth and amelioration from cold.—A. J. Tomhagen, M.D., in *Am. Hom.*, March 1, 1896.

**THE TREATMENT OF DELIRIUM TREMENS.**—Dr. A. P. Williamson recommends the stopping of all alcoholic drinks, the administration of large quantities of hot water to aid in the elimination of the poison, and a diet of highly nutritious and easily assimilated food. Hypnotics are dangerous and should rarely be used. Concerning the remedies which may be indicated in this disease, while there is a wide range of drugs having symptoms resembling those of delirium tremens, the really useful ones are limited, and their indications are fairly well defined.

*Actea racemosa* is very useful in mentally depressed cases, when the tremor is the most prominent symptom, the delirium is of a mild type, and the hallucinations relate to small objects or animals. There is also persistent sleeplessness, as well as great physical restlessness.

*Arsenicum alba* is occasionally indicated in asthenic cases, when the patient is bathed in sweat and profound exhaustion is present; the lips and tongue are dry, and the patient wishes them moistened frequently. The stomach is irritable, food being rejected as soon as swallowed. The hallucinations are visual, and relate to small animals, but to which the patient is indifferent. Great restlessness exists, and suicidal tendency is often present.

*Belladonna* is particularly useful in cases in which there is great mental and physical activity, with a disposition to be violent toward those opposing him. He seems to cherish delusions of persecution, as he is liable to assault a bystander, by biting or striking him. These spells of violence often come suddenly, like a clap of thunder out of a clear sky, and subside as quickly. There is sleeplessness, but with drowsiness, which seems to be the forerunner of sleep, if it were not for the outbursts of violence. The face is very much flushed, and the pupils are dilated and irresponsive to light.

*Cannabis indica*, in the writer's judgment, is the most frequently indicated and the most thoroughly reliable drug we have in our hands. When this drug is useful there may, or may not, be present great violence. While there is considerable talkativeness, there is not the same degree of loquacity as found under some other drugs. The mind is so active that a number of subjects are introduced in a short space of time. Delusions and hallucinations are usually present, and they assume the characteristic form of this drug; they relate to large objects or extended distances or exaggerated spaces of time. They see large animals, or believe they are surrounded with numerous enemies, or imagine the room is of vast size, or that they have been ill months. The face is generally flushed, the pupils are dilated, they perspire profusely, and the principal emotion impressed on the countenance is surprise, although the expression may change frequently, as the different emotions come into play. The pulse may be slow.

*Hyoscyamus* is another most excellent and useful remedy. It is especially indicated where persistent insomnia exists. The hallucinations are terrifying, and the patient makes frequent efforts to escape from his tormentors. There is a jactitation of muscles, rather than tremulousness. Quite frequently the patient keeps his arms waving, or his hands in motion. Loquacity is an almost constant symptom, the conversation being punctuated with profane or obscene language. There are also outbursts of careless laughter, sometimes alternating with loud weeping.

The above list may be almost indefinitely extended, but the few remedies named are those the writer has found especially useful and most frequently called for. It is not presumed to embrace all the remedies which may be indicated, but simply those which will cover the largest number of cases. *Nux vomica*, *opium*, *stramonium*, *ranunculus*, *cantharis* and a host of others have likewise each its place, and many under certain circumstances prove as useful as any we have mentioned.—*N. Y. Med. Times*, May, 1896.

**THE MEDICAL TREATMENT OF APPENDICITIS.**—Before the June meeting of the Homœopathic Medical Society of Chicago, Prof. J. S. Mitchell read an exhaustive paper upon the above topic, covering the experiences of thirty-one years, in which he warmly supported the opinions of Dr. St. Clair Smith, of New York, and of Dr. McArtney, as given in a recent number of the *Medical Record*, to the effect that appendicitis is, in a large majority of cases, fully amenable to medical measures. His early cases were classified as typhlitis, perityphlitis, inflammation of the bowels, etc., but in the light of present differential diagnostics he is able to take from his note-books ninety-three cases of appendicitis treated medically without one fatal case. The author of the paper relies chiefly upon *belladonna* in the catarrhal and recurring cases, and upon *arsenicum* when the conditions point to sepsis. The right-sided pain, the colicky symptoms, the increase in the temperature, the distension, all indicate *belladonna*, while the chills, the hectic symptoms, the diarrhoea (when this is present), the restlessness, etc., indicate *arsenicum*. Other remedies will be useful in numerous cases, but on *belladonna* and *arsenicum* he places chief reliance.—Heat, externally, is usually grateful and beneficial. He has no use for the rubber coil and cold applications in appendicitis. Nor has he to rely upon hypodermics. Occasionally he has resorted to opium by means of the rectum, and also to laudanum applications on the abdomen. If the case points clearly to abscess or perforation he would immediately call a skilled surgeon to operate. But the indiscriminate operating of the present day is not justifiable; and the cry that every appendical pain demands the knife is sheer nonsense.

In the ensuing discussion Dr. T. C. Duncan stated that he had found *bryonia* to be the remedy of remedies for appendicitis and allied conditions, and Dr. A. G. Beebe recommended *mercurius corrosivus*.—*Medical Century*, July 1, 1896.

**PULSATILLA IN PHLEGMASIA ALBA DOLENS.**—Dr. Williams reports the cases of two women, one aged 58 and the other 40 (the latter being of the Allopathic faith), in whom repeated attacks of phlegmasia alba dolens, after confinement, resulted in extensive ulceration of the legs. *Pulsatilla* 2x cured promptly. The ulcerations were very extensive, and the patients were confined to the house. There was in each case much burning and itching. Taking into consideration the cause of the trouble and the appearance of the ulcers, *pulsatilla* was chosen, and it cured, even while the patients continued their usual occupations. No external applications except cold water compresses were used.—*Medical Century*, July 1, 1896.

**A VERIFICATION OF RHUS TOX.**—Dr. Nancy I. Williams reports the case of a woman sixty years of age, who applied for relief from a smarting, burning and itching of her lower limbs. It was so severe as to banish sleep and distract her from her household duties. She was short and stout, and her expression was one of continued suffering. The limbs were much smaller than in health, the skin was drawn tightly over the bones and was of a dark purplish color, varying to a deep red, and shiny as if varnished. It appeared as if this shriveling and color had come from long continued bandaging. In many places the skin was broken down, forming ulcers with irregular edges. Numerous eruptions, large and small, were scattered about. This condition was chiefly confined to the anterior portion, yet extended well posteriorly. From these broken down surfaces a sticky, watery fluid was constantly oozing. Homeopathic treatment had been employed for two years, but little relief had been obtained and that only of short duration. *Rhus tox.* 200th, was prescribed and in six weeks the itching and burning as well as the smarting had ceased, the ulceration had healed and the cure seemed complete. About a year after this the itching, burning and smarting began again, but *rhus tox.* speedily ended it. It did not go on to ulceration and since then there have been no recurrences.

In a second case, that of a man about the same age, the same condition of shriveling and the varnished appearance were present, as the bandaging in this case had been very persistent. Where the skin was intact he complained of the smarting, burning and itching; there was the same form of ulcerations with a watery fluid exuding. *Rhus tox.* was prescribed, and although the cure was longer in coming it came at last and with no other remedy. He had formerly used all kinds of medicines internally and applications externally.—*Medical Century*, July, 1896.

**BRYONIA IN CONSTIPATION.**—Dr. Bryce reports the case of a female patient who suffered from severe and exhausting diarrhea for some time, and was promptly cured by *kali bichrom*. After this the motions became very large, hard and light-colored, and being presently too massive to pass, resulted in obstinate constipation, which nothing relieved for 10 days. With this there developed a severe pain over the right hip, which was worse on motion, and became so violent that the patient could not get out of bed. *Bryonia* 200 was prescribed, which cured both troubles almost at once.—*Monthly Hom. Review*, June 1, 1896.

**SILICA IN NECROSIS OF THE TIBIA.**—Dr. Mackenzie reports the case of a struma girl, st. 13, who was suffering from necrosis of the right tibia. She had been in a hospital and had had several exfoliations of bone removed. The wound was now healed, but threatened to break again. There was a raised eschar above the cuticle, but it was quite dry, with redness of the surrounding skin and tenderness. The pains were very severe at night; appetite fair; bowels constive, the motions being large, hard and dry. *Bryonia* 3x, a dose each night, and *silica* 6x, t.d.s. Next week she reported that the bowels were relieved naturally, and the pains in the bone were better for the first time in many weeks. Repeated remedies for two weeks. The patient then said the pains were gone, and the bowels were regular. The leg looked healthier; the scab and tenderness had gone. *Silica* was repeated, and next time the leg was apparently well, with no pains or tenderness and only the old scars visible.—*Monthly Hom. Review*, July 1, 1896.

# THE AHNEMANNIAN MONTHLY.

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## A STUDY OF ALBUMINURIA AND UREA.

BY EDWIN H. WOLCOTT, M.D., ROCHESTER, N. Y.

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(Read before the Homœopathic Medical Society of the State of Pennsylvania,  
Philadelphia, September 30, 1896.)

THE following cases are taken from the records of the maternity ward connected with the Rochester Homœopathic Hospital.

CASE I.—Mrs. H.; age 20 years; primipara. One urinary examination was made eight days before the confinement. Urine had specific gravity 10.24 and no albumin. The day following labor thirty-one ounces of non-albuminous urine, specific gravity 10.17, were drawn by catheter, and the next day thirty-five ounces of urine were taken by the same method. At six A.M. the following morning the patient was taken with convulsions, which recurred at frequent intervals until 3.30 P.M., when she died. Urine drawn at seven and ten A.M. showed albumin for the first time, which was present in decided amount. There were no casts found, and the only uræmic symptom before this time was a decided irritability of the stomach beginning immediately after the labor.

For the purposes of this paper it may be assumed that this was a case of functional albuminuria, and it is reported to place

on record another case in my experience of the singular condition of albumin occurring in the urine as the direct result of eclampsia, and not its frequent cause, as is supposed.

On page 792 of Cazeaux and Tarnier's *Obstetrics*, we find this significant statement:

"The amount of albumin in the urine increases greatly during the convulsive attack, and generally diminishes after it. This peculiarity has led some persons to inquire whether the eclampsia, instead of being due to the alteration of the urine, might not be the cause of it. I can understand why there might be hesitation in regard to this point, if a single case could be cited in which it had been proved that the urine was entirely free from albumin for several weeks before the appearance of the accidents; this, I believe, has never been done, but often, on the other hand, albuminuria has been known to be present for some time before the convulsions occurred. Besides, when we come to reflect upon the obstruction to the venous circulation produced by eclampsia, we can very readily account for the active congestion with which the internal organs, and the kidneys in particular, may be affected during the attack. Now, it is well known that renal congestion increases the secretion of albumin."

It cannot be stated that albumin did not exist in the case reported "for several weeks before the accident," but we do know that it did not exist for some time before the convulsions occurred.

The urine, you will remember, was examined eight days before and one day after confinement, without manifesting the presence of albumin. Naturally we have the right to expect that when pressure is made by the gravid uterus upon the renal vein or vena cava inferior sufficient to retard the returning circulation in the kidney and cause albumin, the albumin would have appeared sooner than one day after labor, and its occurrence, therefore, must be assigned to some other cause. Neither, in our opinion, does the theory of super-albuminosis obtain, for the reason that the woman was poorly nourished when she entered the hospital, and there was no artificial feeding of exclusively albuminous matters while she was under our care, to produce a temporary surplus of albumin in the blood sufficient to cause albuminuria.

How, then, are we to account for this condition? Largey, I think, as suggested by the author quoted, on the theory of general congestion of all internal organs, and especially congestion of the kidney produced by eclampsia.

When the muscles are in a state of active contraction, the venous blood coming from the muscular tissues is very dark colored. We also know that the muscular system forms a very large part of the entire mass of the body, and is intensely active during a convulsion. Naturally, then, this activity has a great influence upon the color of the venous blood in general. This color, judging from the change produced by the passage of the blood through the lungs, is largely due to the presence of carbonic acid. But highly colored venous blood contains something besides an abnormal amount of carbonic acid. It is surcharged with effete and poisonous materials caused by unusual waste, or an excessive physiological disintegration of the body. The blood now having traversed the lungs, becomes arterial in name only. To accomplish its further purification it must come in contact with the capillary circulation of the kidney, whose function it is to eliminate these *excrementitious substances*. When these are excessive, an abnormal condition of engorgement takes place in the kidney, which is an important factor in renal congestion, and a consequant secretion of albumin.

The obstruction to the venous circulation from a general internal congestion, produced by eclampsia, is easily accounted for and need not detain us.

CASE II.—C. S.; age 23 years; primipara; entered the hospital at 4.30 A.M., June 23, 1896, having had a convulsion, and was delivered by a high-forceps operation at 6 A.M. Sample of urine drawn at 3 A.M. contained a large amount of albumin, many granular casts and only  $\frac{2}{10}$  per cent. of urea. During the day there were repeated convulsions and an increase in the amount of albumin. 5xvi. of urine were secured in fourteen hours. Urea varied from  $\frac{2}{10}$  to  $\frac{8}{10}$  per cent. Patient died at 8 P.M. Child was well nourished; is now alive and doing well.

CASE III.—Mrs. T.; age 19 years; entered the hospital May 27, 1896, and was discharged July 29th. From the time she entered until her confinement a small amount of albumin was present. There were no casts, but a diminished amount of

urea eliminated—two to three hundred grains daily. She was given careful preparatory treatment, as follows: Merc. corr. 3x, Buffalo Lithia Water, hot baths and milk diet. She was confined May 16th without the slightest complication, and the urine soon returned to normal.

All of the foregoing cases, when considered in the light of our present knowledge, indicate:

1st. That albumin in the urine has occurred as the direct result of eclampsia.

2d. When albumin occurs under conditions not eclamptic it is suggestive only, and does not in and of itself, unless especially abundant, cause any serious phenomena.

3d. That with albumin we generally find a diminished amount of urea eliminated.

4th. It is not admissible that urea alone is the toxic agent of urine, for large quantities are often retained in the blood or are injected therein without serious results.

5th. That according to Bouchard, there are at least seven toxic principles of the urine: *A diuretic* urea; a narcotic, unknown; a sialogenous, also unknown; a substance which contracts the pupil, and two convulsives, one unknown and the other an inorganic substance, potass.

6th. "That the toxicity of urine cannot be explained by any one of these bodies singly. Each of them contributes a different share to the general toxicity—the coloring matter,  $\frac{3}{10}$ ; the extractive matter,  $\frac{1}{10}$  to  $\frac{2}{10}$ , and potass. and other mineral substances,  $\frac{4}{10}$  to  $\frac{5}{10}$ ."

7th. "In order that intoxication may be produced, it is not sufficient that the kidney should be diseased; it is necessary also that its permeability should be diminished to a degree such that it can no longer eliminate a sufficient amount of poison."

8th. Regarding the relation existing as cause and effect between the non-elimination of these poisonous substances and eclampsia, it would seem that a peculiarly sensitive condition of the nervous system must co-exist in the majority of cases to produce this disease.

It is our intention to pursue this interesting study in our hospital, and we hope to report more definite results at some future time.

## PROSTITUTION—NO LICENSE, BUT CONTROL.

BY JOHN W. HAYWARD, M.D., BIRKENHEAD, ENGLAND.

IN the September issue of the HAHNEMANNIAN MONTHLY, Dr. Maxwell ventures to discuss the crying evil that is a disgrace to our civilization. This is a subject almost too repulsive and loathsome to be referred to, but it is unfortunately one that has to be put up with, just as the drink trade has, because it too has its source in our very constitution and the circumstances of our life and society—our nature and environments. As a social question, like the drink trade, it can be effectively dealt with only by municipal authorities; but as its frightful results are best known to our profession, it is proper we should render to the authorities all the help we can. It is, however, worse than useless for us to propose means that it is impossible to have carried out or made effective. Absolute prohibition is entirely useless—at any rate so long as there are compulsorily unmarried people, and our nature and the circumstances of society are as they are at present—quite as useless as would be prohibition of urinals and water-closets, whilst our daily requirements remain what they are. As men of the world, let us be reasonable and accept the facts of nature and society. The sexual passion has been implanted within us by our Maker, and we are commanded to use it. “Be fruitful and multiply” is a divine injunction. Indeed, in this matter, speaking generally, we are not free agents—as we are not free agents as to other evacuations: we are under (natural) compulsion, and cannot help it. The sexual passion can no more be absolutely suppressed than can the necessity for other evacuations, or the craving for food and drink, or the necessity for sleep. It may indeed be somewhat controlled, though perhaps not at all times, or under all circumstances; nor can all soldiers, sailors and other necessarily unmarried people make themselves eunuchs or monks or nuns. To prohibit, therefore, would be to act a farce. Municipal authorities must look the matter squarely in the face as a necessary evil which they cannot suppress, but which, as responsible for the good government, the good order, and the health of the inhabitants, they must endeavor to control, just as they have to

control, but cannot suppress, the drink trade. Both are evils, but neither of them can be entirely suppressed; all that can be done is to keep them within reasonable bounds. Both are aggravated or increased by means of temptation, and diminished by absence of temptation; temptation should therefore be kept out of the way; the sexual passion is very easily excited by temptation, more easily even than is the passion for alcohol, and to this many people are far too susceptible. As is the sight of a public house to a drunkard so is the sight of a harlot to a lately liberated soldier and a lately landed sailor, and perhaps to some other unmarried people. It is very easy for the married and monks and nuns, the aged and those who have little susceptibility, natural eunuchs and old maids to say that people ought to exercise self-control; perhaps they would do so were there no strong temptation. Solicitation in the streets is the most effective means of exciting to the indulgence of the sexual passion; this can be and should be absolutely suppressed. The presence of bawdy houses is the next potent temptation; these, unfortunately, cannot be entirely suppressed, but they ought to be banished from respectable neighborhoods; and all attempts to keep them there, or to let houses for such, should be visited by fine or imprisonment, or both. All such money-grabbing sinners as would provide or obtrude such temptations should be driven from all respectable neighborhoods. It may be said that if driven from one place they will set up in another, because there is a demand for them; this may be quite true, and it cannot be denied that there is a demand. There is, unfortunately, both demand and supply. The evil has always existed, and it is to be feared always will exist. This being so, would it not be well to accept the fact, submit to the inevitable, and try to control and curtail it as much as possible? It should not be permitted to obtrude itself in respectable neighborhoods, but should be banished to obscure districts. As it must and *will* exist in spite of all that can be done, would it not be well—under the circumstances—that in certain of the lower districts of large towns the police might be allowed to be somewhat less strict in their supervision; and in these places confine themselves to seeing that something like decency, or at least order, is maintained? In all other places they should see that no solicitation or bawdy houses are permitted. That soldiers and

sailors and other compulsorily unmarried people do and *will* indulge, is a patent and incontrovertible fact; and it is to be feared will continue to be so as long as human nature and human society remain what they are. The best thing to be done therefore, and what can be done, is to confine the evil to certain limited areas; and let it be understood—unmistakably—that those, whether women or men, who are determined to have illicit indulgence must resort to these neighborhoods for it. If the main thoroughfares of towns are kept free from means of temptation the sexual passions of the people will be much less excited than under the present conditions; and if respectable neighborhoods are kept free from conveniences for indulgence, indulgence will be much less frequent than it now is. Keep temptation out of the way, and there will be less sin. “Lead us not into temptation” is the divinely taught prayer.

If judged wise or necessary, the “known to the police” and the “permitted purveyors” in these restricted areas might be subjected to some kind of supervision or examination, so that those affected with disease may be taken to hospital, and thus prevented from spreading the disease further; and all habitual resorters to these places, both men and women alike, should also be subjected to compulsory examination, so as to prevent them carrying disease elsewhere or to innocent persons.

This would not be licensing the evil, but simply controlling, regulating and diminishing it. If such means fail to confine it within narrow limits, the matter is indeed hopeless. Much better early marriage, notwithstanding its many inconveniences.

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#### CAN THE OPERATION OF THE LAW OF SIMILARS BE PROVED?

BY M. W. VAN DENBURG, A M., M.D., FT. EDWARD, N.Y.

DRUGS FROM ALLOPATHIC SOURCES THAT ARE RECOMMENDED BY ALLOPATHIC AUTHORITIES ACCORDING TO THE LAW OF SIMILARS.

#### PART II.

THAT there has been a steady decadence of the study of “the physiological action of drugs,” in the allopathic school from the time of the last edition of Stillé’s great work, in 1872, to

the present, must be evident to every one who carefully compares Stillé with such later authors as Wood, Bartholow, Ringer and Hare.

In Stillé are given many examples, not only of the toxic action of drugs in large doses, but of the equally certain effects of the protracted use of smaller doses; and the latter should be rightfully regarded as equally legitimate effects with the former. In the last-named authors, few, if any, examples are given of the effects of continued small doses, while the effects actually ascribed are often grossly misleading as to the legitimate physiological action, considered from a rational and scientific standpoint.

Stillé's work marked not an era of progress toward development in the study of drugs in the allopathic school, but, strangely enough, a turning-point toward retrogressive atrophy. Take, for example, Hare's description of the physiological action of *hydrastis canadensis*:

"In poisonous doses, *hydrastis* may cause convulsions, followed by paralysis, according to the quantity of berberine or hydrastine present. The latter is more convulsive in its effects than the former. Upon the circulation hydrastine, when injected into the jugular vein, causes a primary fall of arterial pressure, succeeded by a decided rise; and the studies of Cerna have proven that it is an active poison, producing spinal convulsions followed by paralysis." (*Op. cit.*, p. 204.)

And this is all that is given under the head of Physiological Action.

Stillé says: "Teaspoonful doses of the fluid extract," of this presumably poisonous drug, "may be given frequently."

Hahnemann asserts, that "no medicine can be *properly* used to cure the sick until the *entire range of its physiological action* has been *clearly determined*."

Surely, the injection of an alkaloidal extract into the jugular vein, cannot be expected to produce the same physiological results as the administration of "teaspoonful doses of the fluid extract" by the mouth.

Of inexact, partial, unsatisfactory, and unscientific investigation into the physiological action of drugs upon the human organism, no more striking examples can be found than in the pages of the latest writers on allopathic *materia medica*.

Instead of patient and repeated experiments with doses of various sizes, continued for a long enough period to determine the physiological effects upon the actual human subjects, the great bulk of recognized experimentation, in this persistently self-styled scientific, school, is with toxic doses administered by peculiar methods to dogs, rabbits and frogs; methods seldom or never used in ministering the drug to the sick. It seems never to have dawned upon these modern scientists that this is a most unscientific procedure. That among them, some of the deeper students of the effects of drugs have seen another and better way by which to gauge drug-effects, a way which they have *not* followed, will be shown later on.

For the present we will seek such light upon the comparative effects of the drug upon man, and the same drug when used in curing the sick, as we may be able to find from their own pages. In this study we shall compare especially the *results of small doses administered to the sick* with the "*physiological effects*" as set forth by themselves. There are but few drugs where the *actual physiological action* has been fairly determined. Our task is not an easy one, owing to the imperfect, fragmentary and inaccurate reports of the actual effects as given by allopathic authors; but the *general trend of evidence* ought to be enough to arrest the attention of every careful scientific seeker after truth.

Beginning, as promised in my last paper, with a nearly alphabetical investigation, the following is submitted. But this much should be again premised—many drugs have practically no experimental data of any value for such a comparison, because they have no *actual experiments* upon man. Others have only the *transient effects of large doses* given once or twice. Few have the effects of "*the continued use of the drug*," the most valuable of all experiments in determining its "*physiological action*."

*Acidum Sulfuricum.*—"The habitual use of sulfuric acid, sooner or later, enfeebles the digestion, produces colicky pains and diarrhoea, impairs nutrition and is very injurious to the teeth, even when greatly diluted." (Stillé, i., p. 301.)

"It has been used profitably in scurvy and in purpura." (*Ibid.*, p. 304.) "In dyspepsia accompanied by alkaline pyrosis, *but it is no less serviceable when the secretions are acid*; in diarrhoea and cholera morbus of an epidemic type, dependent on atmospheric changes." (*Ibid.*, p. 305.)

"It is useful in acute, or in chronic lead-poisoning." (Stillé, *ibid.*, p. 306), but Wood doubts this (p. 498). (Bartholow, p. 109.)

*Aconitum Napellus.* *L.*—"The first action of aconite in physiological doses produces warmth in the stomach, nausea and oppressed breathing; diffused warmth, tingling, numbness, slower pulse, debility. A more severe dose produces collapse, with lancinating pains in the joints, headache, vertigo, dimness of vision, cold, moist surface, quick, feeble pulse, small, weak and irregular as the collapse deepens; the voice is weak or lost; blindness, deafness, slight delirium and death by syncope.

"In many cases vomiting, diarrhoea, twitchings and tremors follow severe doses.

"Long-continued use of aconite produces severe pains in the head, severe pains in the eyes, with lachrymation, photophobia, heat of the skin, quick pulse and great restlessness." (Stillé, vol. ii., pp. 308-310.)

"Aconite is a powerful antiphlogistic.

"It is of great value in all cases where there is inordinate activity of the circulation." (*Ibid.*)

"It is indicated in morbid states characterized by an excess of motor activity; in inflammatory states of the respiratory organs; in certain forms of neuralgias; in inflammatory states accompanied by arterial tension and fever; in the active form of acute cerebral congestion." (Bartholow, pp. 656-658.)

All authors agree that the action of aconite is very brief, either death or recovery follows a large dose in a few hours.

Stillé is the only one who gives the effects of the long-continued use of aconite. Only by this means are developed those physiological states that indicate the most appropriate use of the drug in therapeutics. In some cases of poisoning and death the stomach and the brain have been found congested. (Stillé, p. 811.)

"The dose of aconite tincture is 1 to 5 drops, repeated one to three hours, *pro re nata.*" (Wood, p. 428.)

Homœopathy gives usually 1 drop, or less, at a dose. The 8x or higher, ten minutes to two hours between doses, of 2 to 5 drops each, in water, 13.

Homœopathy has found aconite, 2x or 1x, very useful in cholera infantum, with small, frequent dysenteric stools of greenish slime, accompanied by unappeasable thirst and rest-

lessness; dry heat; full, hard, quick pulse; tenesmus and sharp pains with stool; the cases arise most frequently from exposure to draft in very hot weather.

*Ammonii Carbonas.*—“*Moderate doses, slight headache, irritative cough and increased secretion of bronchial mucus.*” (Stillé, ii., p. 785.)

“*The action of this drug for a length of time produces pain in the abdomen, occasional diarrhoea, complete loss of appetite, quick, feeble pulse, pale face and loss of flesh and strength.*” (*Ibid.*)

*A case of morbid use of this drug resulted in “great loss of flesh, hectic fever, vast haemorrhages from intestines, nose and gums, loss of all the teeth; he could eat nothing and his body broke out all over in pustules; he died of the highest degree of marasmus.”* (*Ibid.*)

“*The drug is recommended in typhoid pneumonia where the strength fails and expectoration grows difficult; give two teaspoonfuls (of 2 drachms of the salt in 5 ounces water) every two to four hours.*” (*Ibid.*)

“*It is much lauded in malignant scarlatina with exceeding prostration, mucous membranes subject to haemorrhages.*” (*Ibid.*)

*Chronic pulmonary catarrh, broncho-pneumonia, extreme debility of the stomach of drunkards, sick headache and cardialgia are among the affections for which Stillé recommends this drug.*

*Hare says this drug “undoubtedly has an action exactly like the liquid preparations of ammonia.”* (P. 62.)

*Bartholow says “individual differences (in the various preparations and compounds of ammonia) undoubtedly exist.”* (P. 225.)

*Wood gives no physiological account of the drug, but says “it is the best preparation for continuous use and in typhoid pneumonia.”* (P. 338.)

One of the most conspicuous things about this drug, in the latest authors, is the omission of *any definite physiological effects*.

Equally conspicuous are the *undoubted contradictions* as to the important matter of *selecting* “the form of drug for administration.”

*Arsenicum Album.*—This drug, according to Stillé, causes, in

its toxic effects, the following diseases (see Stillé, ii., pp. 811, etc.), and cures the same diseases:

Arsenic causes a chlorosis; and cures a chlorosis.

Arsenic causes an impairment of all the functions of the nervous system.

Arsenic increases the activity of all the functions of the nervous system.

Arsenic causes loss of memory and great dulness of all the mental powers.

Arsenic renders more active all the mental powers.

Arsenic causes great irritability, uneasiness, apprehensiveness, prostration and exhaustion, in connection with other manifestations.

Arsenic cures in diseases where these symptoms are especially prominent and manifest.

Arsenic causes neuralgia of a certain type; it cures neuralgia of that certain type; especially intermittent.

Arsenic causes spasmodic movements; cures chorea.

Arsenic causes fevers of a certain sort.

Arsenic cures fevers of the same sort.

Arsenic causes ophthalmia. Arsenic cures ophthalmia, especially if associated with impetiginous eruptions. But arsenic causes impetiginous eruptions.

Arsenic causes dyspnœa, and cures dyspnœa.

Causes asthma, cures asthma.

Causes severe præcordial pain, constriction, spasms, anxiety, etc.

Causes severe angina pectoris.

Causes chronic bronchitis, with hectic, etc.

Cures chronic bronchitis, hectic and associated symptoms.

Causes dyspepsia; cures dyspepsia.

Causes gastralgia; cures gastralgia.

Causes inflammation of the stomach; cures inflammation of the stomach.

Causes loss of appetite; cures loss of appetite.

Causes burning in the stomach; cures gastralgia.

Causes increased urine, with certain attendants; cures increased urine with the same attendants.

Causes menorrhagia with certain attendants; cures menorrhagia with like attendants.

Causes a fibrinous, false-membranous deposit on the mucous surface of the intestines; cures copious discharges of membranous shreds from the bowels, attended by other symptoms like those produced by arsenic.

Causes rheumatism; cures the same peculiar sort of rheumatism.

Causes ulcers of the nose; cures ulcers of the nose.

Causes ulcers of the mouth; cures ulcers of the mouth.

Causes ulcers on the legs; cures ulcers on the legs.

Causes gangrenous ulcers; cures cancer on the same parts.

Causes scaly eruptions of the skin; cures scaly eruptions of the skin.

Causes eczema; and cures a similar eczema.

Causes psoriasis; cures a similar psoriasis.

Causes pustular eruptions; cures similar pustular eruptions.

Does not cure syphilis; but cures syphilitic skin diseases that have a scaly manifestation.

*The following is a summary of the action of Asafætida, both in its physiological sphere and in its curative action. It is drawn from Stillé, vol. ii., p. 27, etc.*

*In the digestive sphere asafætida causes :*

“ Burning in the fauces ;”

“ Impaired digestion ;”

“ Enfeebled digestion ;”

“ Alliaceous eructations ;”

“ Oppression and fulness of the stomach ;”

“ Nausea and vomiting ;”

“ Distension of the abdomen and discharge of fœtid flatus ;”

“ Colic and burning in the abdomen ;”

“ Increased peristalsis of the bowels ;”

“ Strong inclination to stool ;”

“ Diarrhœa ;”

“ Thin and repeated evacuations ;”

“ Removes intestinal worms.”

“ It also causes increased secretion of the liver.”

*Asafætida cures :*

“ Impaired digestion ;”

“ It augments the appetite ;”

“ It improves the digestion ;”

"It improves the morbid secretions of the mucous membranes and expels intestinal worms;"

"It cures distension of the abdomen by promoting the discharge of flatus;"

"It cures hypochondriasis by the direct action of the drug on the digestive function, which is the starting-point of the disease."

We note here that no disease is here said to be cured by the drug that has not its direct counterpart in the diseased state caused by the "action of the drug on man." Even the expulsion of worms falls under this head, since it is conceded that intestinal worms are the result of an impaired state of digestion, and not the associates of the healthy human being.

*Upon the respiratory system, the action of asafœtida causes :*

"The pulse and the respiration to become slower;"

"The pulmonary exhalations to become increased."

*Asafœtida cures :*

"Chronic catarrh, with or without spasmodic dyspnœa;"

"When the wheezing is considerable and the expectoration difficult from the general debility, or the cough spasmodic, much benefit may be derived from the use of the drug."

*In the sphere of the nervous system, asafœtida causes :*

"General malaise;"

"More or less flying pains in the head;"

"Various nervous and hysterical phenomena;"

"Occasionally, asafœtida increases the sexual desire;"

"It tends to hasten the menses;"

*Cures made by asafœtida :*

"General debility is cured by the property of this drug of imparting vigor without exciting;"

"This drug is one of the most valuable agents that can be employed in the treatment of hysterical cases;"

"In true epilepsy it is perfectly useless; but in hystero-epilepsy it is reported to have cured one case;"

"In nervous apoplexy, or that form which seems to consist in simple congestion of the brain, it deserves a prominent place;"

"The spasmodic affections of girls, at the age of puberty, are frequently cured by the establishment of the menses; the emmenagogue properties of asafœtida may therefore become the indirect means of removing these nervous disorders."

Again note,—no *cure* is here mentioned as effected by this drug (except the indirect cure), that is not like a diseased state caused by the drug in its action on man.

But a still stronger case, in the same direction, is made out by our author. *Look on these two pictures:*

*Asafœtida causes:*

“ Impaired digestion; general malaise; enfeebled digestion; colic and burning in the abdomen; distension of the abdomen (Jorg says enormous distension of the abdomen, and Jorg is the authority quoted by our author); and various hysterical phenomena.”

Says Stillé:

“ In that torpid condition of the bowels which is commonly associated with general debility, when the digestion is imperfectly accomplished, and severe attacks of colic supervene; when tympanitis, sometimes of an immoderate degree, oppresses the breathing and becomes the exciting cause of an hysterical attack, when, at the same time, there are signs of chlorosis, or that disease is fully developed, a combinations of symptoms is presented which causes extreme suffering to the patient and great annoyance to the physician. No single medicine is more useful than asafœtida in removing this.”

*Belladonna.*—“ Dryness of the mucous membrane, especially of the throat; dilated pupils; headache; delirium; quickened or very rapid pulse; occasionally very slow pulse; scarlet rash; spasmodyc movements; severe spasms; sopor; post-mortem shows engorgement of the lungs.” (Stillé, i., p. 900, etc.)

“ *It is recommended* in headache, scarlet fever, delirium and spasmodyc affections.”

“ The rash is said to closely resemble scarlatina (*ib.*, p. 903); and the drug to be prophylactic in epidemics of that disease (*ib.*, p. 922); it is useful in pneumonia ” (*ibid.*)

*This drug admits of an extended comparison*, symptom by symptom, as in the case of arsenic, with the same correspondence between the physiological and curative effects.

*Convallaria majalis. L.*

*First action.*—“ Slows the heart-beat; the rise in arterial pressure is both affirmed and denied.” (Wood, 383–384.)

"Toxic doses of the drug produce rapid and irregular heart-action, the arterial pressure being at first increased; afterwards it falls and death takes place from syncope." (*Wood*, p. 383.)

"Profuse diuresis and purging may also be produced." (*Ibid.*, p. 384.)

"It is recommended in all forms of cardiac weakness, dilatation, fatty degeneration, valvular lesions with failing heart-power." (*Ibid.*, p. 384.)

*Digitalis purpurea. L.*

"Decided doses produce great reduction and sometimes dicrostism of the pulse, and increase of the size and force of the wave; at the same time the arterial tension is increased." (*Ibid.*, 362.)

"Toxic doses induce, after a time, increase of pulse-rate, smallness and weakness of the wave, and lowered tension." (*Ibid.*).

"Useful in all forms of heart-failure with small, weak, irregular, feeble pulse." (*Ibid.*)

The use of convallaria and digitalis by the allopathic school has seldom been homœopathic, because they have used it in too large doses, thereby obtaining its *toxic* effects. Of course in organic heart disease, the mechanical or toxic effects are justified by the end accomplished. *But they are in no sense curative*; they only palliate, deferring the catastrophe for a longer or shorter period.

Homœopathy has found *small doses* very useful in *very slow, intermitting* pulse, and curative when not dependent on organic disease.

The detailed presentation of this part of the subject has been far from satisfactory for several reasons. The quoting of a single drug occupies much space. If only a few drugs are quoted, it will be asserted, "these are mere coincidences, and chance relationships." Nevertheless, time and space will allow only a very limited number. Of those only mentioned by name in the following list many examples exist that are *far more striking* than any given above. Especially is this true of mercury, and of iodide of potassium, of gentian, cascara, ipecac, and hyoscyamus, besides many others.

The similarity of the two sets of phenomena in this list of drugs, cannot be controverted in the case of a single example, if we may trust accepted allopathic authors.

*List of drugs recommended according to the Law of Similars by allopathic authorities :*

Angustura, benzoinum, cannabis indica, cantharis, cascara, cinchona, cocculus indica, copaiba, colchicum, conium, creosote, cuprum ammoniatum, cuprum sulfuratum, dulcamara, gentian, hydrargyrum, hydrocyanic acid, hyoscyamus, iodine, ipecacuanha, lobelia inflata, magnesium sulfuratum, mezereum, myrrh, nux vomica, opium, oleum ricini, oleum tigliae, oleum terebinthinae, phosphorus, physostigma, plumbum, potassii bromidum, pot. bitartras, pot. iodinum, pot. nitras, quassia, rheum, ruta, sabina, stramonium, veratrum viride.

No impartial mind can consider these "repeated coincidences" in the light of chance occurrences. Much less are they the results of skilful manipulation. *They prove that experience is daily and hourly demonstrating, in the hands of every allopathic physician in the land, that small doses cure only in those cases where large doses, or a continued use of the drug, causes a similar sickness.* And as Bartholow declares, "the era of large dosing is a relic of the past," the practice of medicine in the future is bound to become more and more in accordance with the homœopathic standard.

In a subsequent paper it will be shown that the most discerning and philosophical allopathic writers *have seen their way*, but failed to profit by the knowledge they have gained.

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#### PROGRESSIVE GLOSSO-LABIO-LARYNGEAL PARALYSIS.

BY WM. A. HAMAN, M.D., READING, PA.

It has fallen to my lot twice to witness the misery occasioned by this most distressing disease. The gradual but certain destruction of the functions of the organs mentioned is awful to contemplate and pitiable to witness, and one can readily comprehend the hysterical condition that so commonly is associated with the fully-developed disorder. It is seldom encountered, and is most hopeless, nothing having effected a cure.

The seat of the disorder is in the motor nuclei of the medulla. This affection is rarely primary, but secondary to general

degenerative involvement of motor areas. Acute and chronic forms are encountered, the acute generally being hemorrhagic or embolic, or the result of inflammatory softening.

Chronic invasion of the medulla generally occurs in people over forty years of age, and is usually secondary to other degenerative changes. The two cases referred to occurred in a man aged seventy and in a lady of fifty-two years, the case of the man being primary, the case of the lady secondary. The first manifestations of disease in the old gentleman were an indistinctness in speech and the frequent entrance of food and drink into the larynx during eating, occasioning alarming symptoms. It was for this that I was consulted. The case was easily diagnosed. Otherwise the man was as well as could be expected and presented no abnormalities of the muscular system. The facial expression was altered; the lips appearing thick, the lower hanging away from the teeth, and, being parted, there was frequent drooling of saliva, keeping his shirt bosom wet. The voice had a nasal twang, indicating a paresis of the soft palate. Speech was indistinct, and by making him repeat the alphabet it was at once noticed that the dental, lingual and labial letters were very imperfectly pronounced. Swallowing required a special effort, and whenever undertaken he gave it his sole attention, as he felt that his life was in danger during the act. This was the special annoyance to his family, and meal time was dreaded on this account. Baryta carb. was given him on general principles (degenerative changes in the central nervous system of the aged) in January, '92, and he was kept under its influence for months. The disease appeared to be held in abeyance and did not progress. The old man was very much disgusted at not being cured. However, his relatives were better satisfied, and although there was no amelioration, yet, by care, he managed to pass his time comfortably with the exception of the act of swallowing until his death, which occurred, eighteen months later, from an intracapsular fracture of the femur.

The lady of fifty-two years was the mother of two children, one of whom was fifteen years old and an epileptic idiot, the convulsive disease starting when the child was three months old; the other child was perfectly healthy and is now grown and in good health. This lady was healthy, and one day in

cleaning house stumbled backward, and in falling down sat on the sharp edge of a bucket, striking the sacrum at the point of junction with the coccyx. The blow was very severe, yet she managed to clean her house, and about four weeks afterward noticed that in going up a flight of stairs she had some difficulty in making the toes clear the edge of the step. This slowly progressed until walking became impossible, and she passed her time in a rolling chair or in bed. This commencement, by the way, was seven years before she died.

This part of her affliction I diagnosed ataxic paraplegia, due to degenerative changes in the postero-lateral spinal columns. For four and a half years the paralytic trouble was confined to the lower limbs, and although they were useless, yet the untrammelled use of her arms and hands allowed her to keep busily engaged in sewing and other light work.

At this time a paretic condition of the upper extremities manifested itself, with an indistinctness of speech; this was two and a half years before she died, and was progressive.

When I first saw her her speech was so indistinct as to require very strict attention to grasp her meaning. This was very trying to her, as by this time the involvement of the upper limbs was so pronounced as to make writing as a means of communication impossible.

Her appearance was characteristic, thick lips, the lower hanging away from the teeth, the chin reddened by the drooling saliva. As in the other case, the pronunciation of the labial (*b*, *v* and *u*), dental (*f* and *v*), and lingual (*l* and *d*) letters was impossible. The taking of nourishment was a time of extreme danger, and was dreaded by every one, as she had had many narrow escapes from suffocation. It was difficult for her to satisfactorily masticate a bolus of food, as owing to paresis of the buccinator muscle she could not keep it between her teeth, and it would collect between the jaw and cheek, necessitating frequent replacing with the finger. The respiratory muscles were also involved; she could not extinguish a lighted candle by blowing if it was held close to her mouth, neither could she whistle, this being due, in great measure, to an inability to properly pucker the lips. For months before she died she was unable to communicate with those around her; speech was absolutely unintelligible and writing was a mechani-

cal impossibility. Is it any wonder that men and women so situated should become emotional, hysterical?

This lady was one of more than common intelligence, and never, during the course of her long illness (seven years), suffered any pain, and yet, without any cause, would indulge in the most distressing screams and moans, frequently interspersed with spells of crying and laughing. This howling she would occasionally keep up during a whole night for many in succession, greatly disturbing the neighbors, and, in consequence, pressure was brought to bear upon me to compel me to give opiates. This I refused to do on my own responsibility, as they too seriously interfere as depressants with the respiratory centres. Other hypnotics, chloral and bromides, that had been successful, were unavailing at that time, and trional and sulphonal were as yet unknown. I left one-eighth grain doses of morphia to be given on their own responsibility, but as a sister of this lady had met an untimely death through a druggist putting morphine instead of quinine into a malarial mixture, it was not given for a week. However, their patience became exhausted one night of more than ordinary screaming, and four one-eighth-grain doses were given. She sank into a quiet sleep from which she never awoke.

At the commencement of my attendance arnica was given for some time, and, in fact, improvement for a time was noticed, but I suppose the wish was father to the thought. Plumbum met., on the recommendation of Hart, was given for a time, but it was only too apparent that the case was hopeless. One might as well expect to cure a case of infantile palsy dependent upon destructive anterior polio-myelitis as this disease when the motor nuclei have been destroyed.

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#### SOME REMARKS ON LAPIS ALBUS.

BY W. A. DEWEY, M.D., NEW YORK CITY.

(Read before the American Institute of Homœopathy, Detroit, June, 1886.)

THIS remedy, the silico-fluoride of calcium, was introduced by Dr. Grauvogl about 1874. It came about in this way: Grauvogl was anxious to find some substance which would defy

chemical examination, and yet be an effective homœopathic remedy, so that he could, as he expressed it, "hammer Liebig's nose into the truths of homœopathy."

Being at Gastein, in the Valley of the Asche, which takes its source from the base of the Tauern Mountains, he noticed that many of the inhabitants of the valley were afflicted with goitre. He attributed this to the water they drank, which he found to be impregnated with a species of gneiss. He also found that his own thyroid gland began to swell after drinking of the water. He therefore triturated some of this gneiss and began to use it with success in certain affections, and also to make provings of it, using the sixth potency.

Liebig, however, died in the meantime, and the nose-hammering process being unnecessary, Grauvogl made known the name of the remedy hitherto secret, and sent some of it to Dr. Carl Bojanus in Russia, and to others, that they might experiment with it.

The provings of *lapis albus* were but fragmentary, the most constant symptoms being a persistent *burning*, stinging pain in the breast, cardiac region of the stomach and uterus. These pains were at times very intense. It excited moreover a marked effect in the thyroid gland—enlarging it.

The early reports of the cases of goitre cured with this remedy in potencies ranging from the 1st to the 200th are quite numerous. Another affection in which it has been used successfully is cancer, although open cases of cancer are said not to have been benefited by it. The persistent pain in the mammary region, coupled with glandular hardening, would suggest its use in beginning cancer of the breast.

The sphere of action of the drug may therefore be said to be: Goitre, certain carcinomatous affections and scrofulous glandular affections. It has, I believe, been successfully used in lupus and in cataract.

My experience with this remedy, and I have been somewhat interested in it, dates from about 1876. At that time a member of my own family had an enlargement of one of the cervical glands. It was nearly as large as a hen's egg, and had a soft, doughy feel. Under *lapis albus* 6, prescribed, I believe, by Dr. G. E. E. Sparhawk, now of Burlington, Vt., the swelling speedily and completely disappeared. A peculiar and unusual

symptom noticed by this patient while taking the medicine was a marked increase in the appetite, it became ravenous.

Since that time I have used the remedy in many cases of scrofulous enlargement of the cervical glands, and find that it is almost specific where the glands have a certain amount of elasticity and pliability about them, rather than a stony hardness, such as might call for *calcarea fluorica*, *cistus* or *carbo animalis*.

It has been pointed out to me by Dr. Martin Deschere, who was to have discussed this paper, but who is unfortunately absent, that the remedy seems to effect the connective tissue in and about the glands rather than the glandular tissue itself, and he was to have presented the report of a couple of cases illustrating this point.

One case in particular which I recall was a young lady about 20 years of age, a natural blonde, skin fair, bluish white, showing prominent veins, who had a glandular enlargement in the right supra-clavicular region nearly the size of a goose-egg, and one somewhat smaller a little further back in the interval between the sterno-cleido-mastoid and trapezius muscles. These had a certain amount of hardness, but they were movable, others of the cervical chain were also enlarged, the right side being the only one affected. As the young lady was engaged to be married, these unsightly lumps were very distressing. *Lapis albus* 6, a powder, 4 times a day, in a week caused a marked diminution of the size of the glands, and in three weeks they were not noticeable, and eventually entirely disappeared. This patient also had a ravenous appetite while taking the remedy, an unusual thing with her; her anaemic color and complexion were also greatly improved.

The most remarkable effect of the use of this remedy I have had was in a case of goitre in a lady of about 35, blonde, who had for over a year noticed a gradual increase in the size of the thyroid gland until it was as large as a good-sized fist when she came to me. Both halves of the gland seemed to be equally involved. It did not appear to be of the encapsulated variety. This patient had received previous homœopathic treatment, having had *spongia*, *iodine*, *thuja*, as well as some other remedies. *Lapis albus* 6 was prescribed, a dose every three hours. The swelling began to disappear at once, and contin-

ued to diminish in size until it completely disappeared, and at the present time over five years have passed with no return of the trouble. In this case the appetite was not specially affected, though it remained good throughout the treatment.

In another case of enlargement of the cervical glands of the left side in a school teacher, *lapis albus* 6 was given. There were no symptoms leading to any other remedy. The patient was apparently perfectly healthy; the gland, which was the size of a hen's egg, promptly began to lessen in size, and doubtless would have disappeared entirely had the patient continued treatment. From some unaccountable reason she ceased coming in the midst of rapid improvement.

*Lapis albus* in cases like the foregoing should, I believe, be given in repeated doses, and herein I concur with a point brought out in this section the other day by Dr. George Royal, namely, that in certain chronic cases it is needful to repeat the dose oftener than in acute cases. It may be a deep-acting remedy, like its near relatives, *silicea* and *calcarea fluorica*, but I have never had any experience with it in potencies higher than the 6th, nor in single doses permitted to act for a long time. Grauvogl observed that in cases where malarial conditions had existed, relapses of these are apt to occur under its use, a further evidence of its deep action.

It has also proved useful in my hands in the common chronic glandular swellings in scrofulous children. I have succeeded with it after the *calcarea* preparations had failed.

Grauvogl reported the case of a carcinoma of the cheek in a woman aged 50, cured by *lapis*, her countenance assuming a ruddiness and freshness unusual with her. He also reported the cure of five cases of uterine cancer with the remedy.

It would seem indicated in anaemic and chlorotic conditions. I have noticed that these conditions have improved under its use when prescribed for its action on the glands. Indeed, I look upon an anaemic condition as an additional indication for its use.

In enlargement of the mesenteric glands *lapis albus* may be indicated. Dr. Soenens, in the *Allgemeine Homœopathische Zeitung*, reports a case of diarrhoea with enlarged mesenteric glands cured with *lapis albus* 3. He considers it specific in affections of these glands. It certainly acts very rapidly in causing as well as in curing glandular enlargements.

It has been recommended as an important constitutional remedy in dysmenorrhœa. Dr. Whiting, of Danvers, Mass., uses it in subjects of a lymphatic temperament with indurated glands and pain preceding the flow. It seems to mitigate the pain and swelling of the mammae, which are sometimes accompaniments of dysmenorrhœa.

It is also mentioned as a remedy for cataract, but to what extent it has been used with success I am unable to state.

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### BORAX.\*

BY F. H. PRITCHARD, M.D., WEAVER'S CORNERS, OHIO.

1. BORIC acid is not borax, for it is a more powerful drug, though the action of the two are probably similar. Corrosive sublimate is not calomel, though the chemical formula is not much different. I thought that I saw an advantage in employing the uncombined acid in thrush instead of the combination borax.

2. Possibly boric acid and the borates are homœopathic to this disease, as their influence is so satisfactory here, but the *Cyclopaedia of Drug Pathogenesy*, which is supposed to contain all the reliable provings and poisonings of our *materia medica*, does not present any that contain buccal symptoms. It being a drug requiring a long time to develop symptoms, the provings might have been too short; perhaps it does not produce mouth symptoms readily in patients over certain age. At any rate it does not seem to have an energetic elective action upon the mucous membrane of the mouth.

3. With all the recent experiments with borax in epilepsy, and the records of its side and after-action upon the skin, hair, etc., it is peculiar that no buccal symptoms were noticed; stomach and intestinal symptoms are reported.

4. An indication unsupported by pure pathogenesy and pathology is empirical. Homœopathic *materia medica* probably contains as many empirical indications as those ably sup-

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\* A reply to Dr. J. M. Christine's criticism (October number) of my article on "Boracic Acid in Thrush in Children," in the August number of the *HAHNEMANNIAN MONTHLY*, 1895.

ported and fixed upon a solid base. If one examine the journals and books of the period when our present *materia medica* was forming, one will find any number of symptoms that were recorded as characteristic because they were removed by this or that drug. If all provings are reliable, why are so many writers urging us to reform the *materia medica* and devising ways and means thereto? The works cited by Dr. Christine in refuting my statement are, excepting those of Allen and Heinigke, *clinical*, as their titles indicate; a work on *clinical medicine* is bound to contain any amount of empiricism. As to the other two, they may also be fallible; I doubt if Heinigke's work is so recognized as pure pathogenesy.

To conclude, I do not say that the indications for borax or boric acid in thrush in children cannot be supported by pure pathogenesy and pathology, yet I claim that the provings have not yet been made that do this. I readily admit what the critic states with regard to the rôle of micro-organisms in provings; a drug will not produce a given germ, but will give incidental germs an opportunity. I am glad that he has kindly taken it upon himself to criticize as well as to give his experience in this affection. A friendly discussion in one's journal can only be instructive and interesting.

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## USE AND DISUSE.

BY W. E. BOTZELL, M.D., NARBERTH, PA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

IT is a generally recognized fact that the increased use of any structure or organ in the animal anatomy, within certain limits, results in the enlargement of that part, and disuse of an organ or structure usually results in its atrophy or degeneration.

The development of an organ through use may be readily illustrated: thus, when a young person actively engaged loses a limb, the remaining limb, being more used than formerly, will rapidly increase in strength.

A case of this character is recorded by J. Bland Sutton

(*Evolution and Disease*). The subject was a woman, fifty years of age, who had her great toe amputated, including the metatarsal bone. Six months after she had regained the use of the foot, the second toe had greatly enlarged and stood out from its fellows in such a way as to resemble in size and general appearance the lost toe. When the case was exhibited before the class the enlarged second toe, possessing such a strong resemblance to, was mistaken for the hallux.

This illustration is of significance and importance, the very rapid development of the toe being the result of the large amount of use which it serves in those members of the mammalia which maintain an erect or semi-erect position. These same facts apply equally well to the thumb, which is proportionally so much stronger than the other digits.

The gradual enlargement of a digit and its transmission to succeeding generations through heredity are well illustrated in the ancestry of our modern horse. The horse, as we all know, walks upon its hoof; this hoof is a modification of the nail and serves as the end covering of the single digit which the horse possesses. On each side of this functional digit is found two bones known as splint bones; these at one period in the life history of the horse were well developed into functional toes, but as they were of little or no use to the animal, they have through disuse almost disappeared and now are merely vestigial structures.

Relative to this subject Prof. E. D. Cope (*Origin of the Fittest*) says: "The reduction in the number of toes is supposed to be due to the elongation of those which slightly exceed the others in length, in consequence of the greater number of strains and impacts received by them in rapid progression, and the complementary loss of material available for the growth of the smaller ones. This is rendered probable by the fact that the types with reduced digits are dwellers on dry land, and those that have more numerous digits are inhabitants of swamps and mud. . . . The mechanical effect of walking in the mud is to spread the toes equally in opposite sides of the middle line, as in the cloven-footed types. In progression on hard ground the longest toe (the third) will receive the greatest amount of shock from contact with the earth. There is even reason to believe that shocks, if not excessive, encourage growth in the

direction of the force applied. This is strongly suggested by the relations between the length of the legs and the rate of speed of animals, and the lengths of the teeth and their long-continued use."

Many interesting illustrations of enlargement from use can be cited in the muscular system and in the paired organs. Thus frequently after the removal of a testicle, its fellow greatly enlarges, and compensates to a certain extent for the lost one. Similar enlargement occurs after the removal of a kidney.

A structure about which much has been written and said, and which is probably the result of disease, is the vermiform appendix, which is doubtless the remains of the much elongated cæcum which is found in the majority of the herbivorous mammals. In man and the four anthropomorphous apes, the lower end of the cæcum has attached to it the vermiform appendix, which varies in length from about two to eight inches; this appendix is also found in the wombat, a marsupial mammal, which has many characteristics of the rodents.

In the orang the appendix is longer than in man, and in the human fœtus it is proportionally more developed than in the adult. Occasionally the appendix is absent.

A very interesting paper on this subject was recently published by Dr. Edward Cranch, of Erie, Pa., in which he endeavors to demonstrate that the appendix is not a useless organ, but that its function is to secrete mucus for the lubrication of the large intestine. Of course all mucous membranes secrete more or less mucus, but the quantity secreted by the appendix would certainly be inadequate to be of any special service in the human economy, when we consider the variability in the size of the appendix, and its occasional absence, besides, after the removal of the appendix the individual realizes no inconvenience from the loss. In the paper referred to the mucus secreted by the appendix is given the same status as the saliva, gastric juice, pancreatic juice, etc.; certainly none of these secretions could be discontinued, as can the mucous secretion of the appendix, without causing deleterious results upon the system.

The teeth of modern civilized man show to a certain extent the result of disuse. This is owing to the manner in which our food is prepared, the thoroughness of mastication which

is practiced by savage races not being necessary for civilized man. This theory is confirmed by the fact that the third molars, or wisdom teeth, are with each succeeding generation becoming more and more rudimentary. These teeth are now usually the last to make their appearance in the jaw and the first to disappear; they are smaller and more variable than the other molars, and have only two separate fangs. In the older remains of man they have three separate fangs, as they still have in the Melanian races.

In the organs of special sense the results of use and disuse are easily recognized. Thus, for example, when hearing is lost in early life in one ear the power of hearing becomes very acute in the remaining ear. In blind persons the sense of hearing is usually very acute, it compensating to a certain extent for the loss of sight.

Exceptionally fine development of the special senses is frequently met with in certain occupations, as the acute hearing of the musician, the sight and touch of the artist, engraver, etc.

The result of use is well expressed in the old adage of "Practice makes perfect;" this could be improved upon I think by inserting *within certain limits*, because excessive use of a part, in some cases at least, results in the extermination of other characteristics. Examples of modification caused by use and disuse can be found throughout the whole of the animal world, and these factors, I think, can be considered as the most important of the causes of morphological variation.

Among both wild and domesticated animals illustrations can be cited in abundance. The wings of the birds of oceanic islands have diminished in size, owing to disuse, as likewise have the eyes of many cave animals. In some birds the wings have so degenerated that they are of small value as organs of flight, as, for example, the wings of the ostrich, the Great Auk, now extinct, and some domesticated birds. Among the birds of prey, the flesh-eating birds, the muscular walls of the gizzard are comparatively thin, while among those birds which subsist upon grain the walls of the gizzard are quite thick.

The direct cause of enlarged parts through use is irritation and additional blood supply, which constitutes increased nutrition. This increased nutrition is caused by such stimuli as

irritants, certain conditions of the nervous system and environment.

The scales of serpents, the feathers of birds, the quills of porcupines, and bristles of hogs are like hair, epidermis, and horn, all modifications of the epithelium, and are the result probably of different internal and external conditions to which the animal has been subjected. These modifications are usually transmitted to succeeding generations.

Development through use also furnishes an explanation of the power of scent in many animals, the sight of the birds of prey, and the cunning of foxes and wolves.

Disuse, on the other hand, usually follows defective nutrition, the *causa causarum* of which is probably environment. Thus in the case of the teeth of civilized man the environment has been such that it is not necessary for us to use our teeth at present to such an extent as man formerly did, and consequently they have degenerated, and as continued degeneration can, and does, result in extinction, Prof. Haeckel and others have ventured to prophesy that unless the teeth, and some of the other structures possessed by man, are used more than they are at the present time, that ultimately they will totally disappear.

It seems to me that these facts are of the greatest importance not only to the biologist, but also to the practical physician. I think there is too much of a tendency among physicians to correct physical variations, without taking into consideration the laws of heredity. When cases are thus treated, while, of course, in the majority of instances they are benefited, nevertheless the possibilities of hereditary transmission of these abnormalities to succeeding generations is increased, and thus does not tend to the improvement of the race. Thus in cases where the various supports, as the truss, for example, are used, and also in using lenses for the correction of errors of sight, when relief only is obtained and not cure. The result is that the race must ultimately suffer in consequence.

According to the methods of nature each useful organ or structure will ultimately perfect itself, *i.e.*, will adapt itself to its environment. By the mechanical methods now in vogue, perfection will never be obtained. It is easy to recognize that our methods of treatment are not ideal, but to suggest the

remedy is practically impossible. All that can be said is that we should see that every patient, including every organ and characteristic of that patient, is adapted, as nearly as possible, to the environment in which he is placed. This can be secured, theoretically, by adapting the subject to its environment, or by modifying the environment to the needs of the subject, or by changing both subject and environment, making each as perfectly adapted to the other as possible.

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### UTERINE SYMPTOMS RESULTING FROM MOVABLE KIDNEYS, WITH A DESCRIPTION OF AN IMPROVED OPERATION.

BY SIDNEY F. WILCOX, M.D., NEW YORK.

(Presented at the American Institute of Homœopathy, Detroit, June, 1896.)

It is a well-known fact that the condition known as movable kidney gives rise to many symptoms which are likely to be attributed to other causes. Patients are treated for many other diseases, such as indigestion, liver trouble, weak heart, cystitis, and uterine diseases.

In fact, the patient is treated for many or most of these diseases before the real trouble is discovered, and I confess that in a number of cases I have not suspected the existence of a movable kidney until I discovered it incidentally while examining the abdomen for something else.

Uterine diseases are most frequently simulated, and most patients are treated for the symptoms which are supposed to arise from disorders of the uterus. In fact, most of the cases which have come under my observation have undergone such treatment, and some of them for prolonged periods of time. Frequently, associated with the supposed uterine symptoms, are many hysterical manifestations, which, of course, are naturally attributed to the disturbed uterine functions.

It would not be of much use to detail special "uterine" symptoms as those arising from movable kidney, because this would involve bringing in every symptom that could, by any possibility, be ascribed to uterine derangement. But, as a rule, all symptoms are especially aggravated during the menstrual

period, and this is one reason for attributing the uterus as the cause. This is not always the case, however. I have two patients with movable kidney who experienced great relief during the period, but these are exceptional cases which I am unable to explain.

I believe sterility may be traceable to movable kidney. I have two ladies among my patients who have this trouble, and neither of them conceived until after the discovery of the loose kidney, and its confinement by means of a well-fitting bandage and pad. Both had desired to have children, and in one of the cases the patient had been married for a number of years. Both had peculiar symptoms, whose origin it was difficult to trace. In one of them, although there were no objective signs of uterine disease—the uterus being perfectly healthy and the cervix easily permitting the passage of the probe—still she suffered greatly at each period, and was always several days late in “coming round.”

After discovery of the true cause of the symptoms the period came on time, and for the first time that she could remember she had no pain, although previously she had been obliged to remain quiet during the first day.

Both of the above-mentioned cases conceived within a short time after the support of the kidney was begun with bandage and pad. Of course, one cannot reasonably argue from only two cases that movable kidney is a frequent cause of barrenness; but it would seem, from the coincidences in the cases cited, that when movable kidney and barrenness exist in the same patient, the latter condition might be the result of the former.

I have observed also another important fact, and that is, that when pregnancy is well advanced, the symptoms referable to the kidney are likely to disappear and the patient enjoy good health. This is due to the enlarged uterus pressing upward, and thus pushing the kidney back into its place. After delivery, of course, the former symptoms may return, and even be aggravated by the greater laxity of the abdominal walls.

As to the treatment of this condition, the only methods which offer any chance of relief are such as involve mechanical means. The palliative measure, by use of the bandage and pad, gives relief in many cases. In some of them the relief is

complete, in others it is partial, but so marked that they prefer to suffer a little to undergoing an operation. In others, the bandage and pad are of no use whatever, and these are the ones who require an operation.

In Germany some physicians have advised the patient to lie flat on the back for several months until the kidney grows fast in its place. To the writer such expectation appears absurd.

The bandage requires great care in fitting and adjustment, and the most careful measurements should be taken, and then the bandage should be tried on before finishing. The pad should be slightly wedge-shaped, with the base downward. The patient should *always* apply the bandage while lying on her back, after pushing the kidney back into place.

It is my custom to advise the operation of nephorrhaphy *only* after a trial of the bandage, and when it is found to be unsatisfactory, and I have a number of cases who are satisfied with the results of the palliative treatment.

Regarding the risk of the operation, I think it is small. If the peritonaeum is not wounded there is little danger, and thus far I have had no bad results.

In the last case, where I operated on both kidneys at the same time, I modified, and I think materially improved, the technique of the operation.

The external incision is made, as usual, parallel with the 12th rib, and a little below it, and all the tissues divided until the muscles are reached. Then, instead of cutting through the muscles (the obliques and transversalis), their fibres are *separated* and drawn aside with strong retractors. This gives access to the kidney without injuring the integrity of the muscles, and the operation is less likely to be followed by hernia. Another improvement consists in stitching the everted fibrous capsule of the kidney to the inner surface of the abdominal muscles by means of kangaroo-tendon sutures. This remains undissolved longer in the tissues than catgut, and is for this reason preferable.

I do not think it is absolutely necessary to pass any of the sutures through the kidney itself, although I have done so in a number of cases. While the kidney is very tolerant of surgical interference, I do not think the amount of extra adhesion gained compensates for wounding the organ.

McBurney packs the wound with iodoform gauze, so that it will heal by granulation and the kidney be held in place by a strong cicatrix. I have tried this, but have not been able to see that the resulting cure was any better.

I offer this short and incomplete article with the hope that it may draw attention to the possibility of movable kidney being the *real* cause of symptoms which may, apparently, arise from disturbed uterine functions or uterine disease, but which do not yield to treatment.

NOTE.—On October 8, 1896, two days before looking over the proof of this article, I received a visit from my tenth case. When she came to my office she was obliged to tell me who she was—the change being so great that I did not recognize her. She was sent to me last winter by Dr. J. Montfort Schley, and at that time was a complete wreck. She suffered intensely and almost continuously from severe headaches and nausea, and spent almost all of her time in bed. She was very thin from lack of nourishment, and was in a most miserable condition. Both kidneys were found to be movable, and both were fixed at the same operation. The result is more than surprising. She has gained from twenty to thirty pounds in weight, looks the picture of health, and has none of the old headaches or nausea. This patient had been treated for uterine disease for a long time by physicians in the distant city where she resides.

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#### THE USE OF BORIC ACID POWDER IN DEEP OR CAVERNOUS WOUNDS.

BY J. W. HASSLER, M.D., OF PHILADELPHIA.

IN the past two months I have been using boric acid powder extensively in the treatment of cavernous or deep wounds, either produced by some inflammatory condition or with the surgeon's knife. Since 1702, the date of its discovery, it has been used as a powder in dressing different skin lesions, those using it seeming to entirely ignore its real virtues. Repeatedly its power of preventing putrefaction has been described, and undoubtedly this power is due to its destroying bacteria; therefore having this action it is an antiseptic agent.

Richter ascribes to it stimulative, antispasmodic, anodyne, sedative, narcotic and antiputrescent virtues.

From my observations I find it to be a persistent stimulant, causing a rapid exudation of plastic lymph, and adding to this its antiseptic virtue, we have an agent most suitable to those cases where cavities are existing due to molecular death, or those produced by removal of large tumors, entirely obliterating those cavities, causing a scab to appear upon the surface, if an open wound, and healing by first intention if sutured in from one day to two weeks, depending upon the extent of the cavity. I have been asked what becomes of the powder; the most plausible explanation is, it being readily soluble, is dissolved.

My mode of applying it is, after thoroughly removing all broken down tissues, if due to some ulcerative process, filling the cavity with the powder, and if possible to approximate the edges of the opening, dressing the wound externally with sublimated gauze. The same procedure is gone through with following the removal of tumors and adenoid growth leaving cavernous spaces.

The following are a few cases:

**CASE I.**—Boy; age, 4 years; caries of the tibia. Following the usual operation of curetting and thoroughly removing all dead bone, filled the cavity with powder, sutured with black silk and silk-worm gut, dressed externally with sublimated gauze.

Was not redressed for six days; found primary union, except at lower angle of wound, due to the tearing out of one of the sutures, leaving a granulating surface the size of a dime; redressed with boracic acid powder; complete union in two weeks.

**CASE II.**—Mr. W.; dispensary case. Fingers amputated seven months ago; union by first intention at that time; returned to dispensary first week in February; found abscess along line of union; incised found spicules of bone; these were removed; wound kept open for one week with packings of sublimated iodoform gauze, to be certain of the presence of no more dead bone. Cavity two inches in depth, three in length; filled with boracic acid powder; did not suture opening; returned in forty-eight hours; complete filling up of cavity had taken place, scab remaining upon surface; redressed, plain sublimated gauze; returned in three days; scab removed, leaving a clean citatrix; discharged.

CASE III.—Miss S., aged 14. Adenitis—cervical glands; removal; cavity remaining three inches in length, two in depth; treated as in former cases; sutured with black silk; redressed in five days; complete union.

CASE IV.—Miss M.; Adenitis—cervical glands; tubercular. Thorough curetting; filled cavity with the powder; wound allowed to remain open. The dressings became displaced; she called the following day; found the cavity fully half closed; after thorough cleansing with peroxide and bichloride irrigation, repeated the former dressing; saw the case in four days; complete closure of cavity, allowing granulating surface; upon the next dressing cicatrix perfect; discharged.

CASE V.—Mr. C. Suppurating bubo. Incised; curetted; treated with boric acid powder; sutured with silk-worm gut; returned in four days; upon removing the dressing found a suppurating wound, due most likely to faulty antiseptic technique at the time of suturing; removed sutures; found the cavity partly filled up; redressed with the powder; treated as an open wound. In three weeks union perfect.

Dr. Carter reports a case of suppurating bubo, the cavity the size of a large apple, treated in the same manner, followed by a rapid filling up of the cavity. I could report numerous cases, but the above will suffice to show the efficacy of boric acid powder in deep or cavernous wounds.

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#### SOME CONSIDERATIONS ON A PRACTICAL CLASSIFICATION OF DRUGS.

BY A. A. RAMSEYER, SALT LAKE CITY, UTAH.

IN looking over the homœopathic *materia medica* the beginner is discouraged by the multitude of similar symptoms enumerated under the different drugs. Attempts to classify the drugs and to find out their characteristic effects have not been lacking; but so far none seems to have “hit the nail on the head.” The following considerations are offered as an essay to throw a dim search-light upon this dark field,

In 1836–37, during an epidemic of influenza, Dr. Benjamin Ridge, of London, England, made, by the study of the tongue, some very important discoveries. He published his ideas in 1844, in a work, *Glossology, or the Additional Means of Diagnosis of Disease to be derived from Indications and Appearances of the Tongue*.

His ideas were developed in subsequent works, especially in this one, *Ourselves, our Food, and our Physic*, London, 1884.

Among the principles laid down by Dr. Ridge: "One wonderful and beautiful law is here set forth in marvellous simplicity, which, when once understood, will give a power and a degree of certainty over disease which has never yet been attained." "In disease, the tongue may become furred, and coated of all colors, moist as well as dry; on the other hand, it may become perfectly denuded of all fur or coating, and present a red, crimson, or scarlet appearance, glairy, glazed, dry or moist." "The white or furred appearance of the tongue denotes a congestive or acid condition of the system, and the red appearance denotes an inflamed one or a want of acids." Hence, when the tongue is *white*, Dr. Ridge gives *alkalies*, but when it is *red, acids* instead are indicated.

To further illustrate Dr. Ridge's ideas, I will again quote from his work, *Ourselves, our Food, and our Physic*, chapter xii., on Measles, Influenza, and Scarlet Fever: "Measles and influenza illustrate some ill-conditioned states of the system affecting the mucous membranes. In both these there are watering of the eyes, running at the nose, coughs, sneezing, etc. . . . The tongue in measles is generally white and furred as in other congestive actions. . . . If the tongue is white, furred, or coated, small and frequent doses of ipecacuanha wine with the alkalies. . . . If the tongue is clean, without being very red, give small doses of ipecacuanha wine, combined with dilute sulphuric acid."

"Scarlet fever is totally opposed to measles. Measles is the type of the congestive or venous, and scarlatina of the arterial or inflammatory fever. In scarlet fever, the medicines found to be beneficial prove that the system requires elementary support, and should be of an acid character. Acids and anodynes are needed. Acids are tonic, and add to the system that of which it is deficient; whilst anodynes or opiates arrest the activity of the fire. These medicines should be given very frequently and swallowed slowly, because the acid acts as a gargle to the ulcerated throat. Belladonna, on account of its peculiar action in all arterial diseases, and its sedative effect in highly excited nervous actions, is very useful. Frequent spongings over every part of the body with warm water and

vinegar—one part of vinegar to two of water—is most grateful. Nothing is more grateful than the burning of vinegar in the room, by pouring a little on some hot coals in a shovel. Here may be mentioned the fact of the distinct acid and alkaline treatment even in what is breathed or smelt to. In all congestive or acid actions, ammoniacal smelling-salts are as proper to the system as the alkaline treatment by medicine; whilst in those cases where the acid treatment is called for, the aromatic vinegar and vinegar fumes are most grateful. The drinks should be lemonade, acidulated barley water, etc., and all should be taken cool."

So far Dr. Ridge. It is only two years since I became acquainted with his writings. Some six or seven years ago, I had read in some of Dr. Scudder's works (of the Eclectic School) about the two different indications given by the tongue, but don't know whether these two distinctions (red-tongue, acids; white-tongue, alkalies) were original with him or not. What is remarkable, and the point to which I wish to draw the attention, is the fact that belladonna, which to every homœopathist is known as a leading remedy in scarlet fever, is used concurrently with acids. In Rau's *Organon* (1847 edition, p. 119) I read : "It is as yet very little known that *the action of belladonna is increased to an extraordinary degree by vinegar.*" And again, on p. 194 : "*Acids, for instance, neutralize aconite, kali, natrum, and ammonium.*" Hence, the only conclusion I can draw is, that *belladonna acts like an acid, and aconite like an alkali*, since the action of the one is increased by acids, while that of the other is annulled by them.

One more quotation, and I hope to be through with authors; this one is from my own countryman, the old renowned alchemist and physician, Theophrastus von Hohenheim, better known as Paracelsus. In his book *De Gradibus et Compositionibus Receptorum et Naturalium*, which was completed by Scholia in *Libros de Gradibus et Compositionibus*, he says : "Praeterea observanda est Regula de coloribus, ut centaurea qui est rubea, ergo calidae naturae: Lilium quod est candidum, igitur frigidae naturae. (Scholia: Virtus in colore est sita. Perfecta anatomia sita est in virtute.) Quidquid est viride, fuscum, calidum ex(s)istit . . . . Quidquid autem est candidum, lividum, nigrum, hyacinthinum, frigidum est, reliqui colorcs sunt calidi. (Scholia: Quidquid

est de rubeo, de viriditate, de citrinitate (tate?) id est gelb, calidatis est. Quidquid est albi vel lasurii, id est bloui frigidum est."

These lectures were delivered in Basle, Switzerland, in 1827, and likely in German and Latin.\*

The above in short translation would read: Colors indicate the nature or virtue of things (viz., whether warm or cold). Red, yellow, green are warm (calidum), while white, livid, black, and blue are cold (frigidum).

Paracelsus did not know anything, I suppose, about the spectrum of the solar rays, which reads: Red, orange, yellow, green, blue, violet. We know that there are three classes of rays in the solar spectrum—the calorific or heat rays, the colorific or luminous rays, and the actinic or chemical rays; the luminous rays correspond with the yellow part of the spectrum; the actinic rays augment in intensity from the red towards the violet, while the calorific rays augment in intensity from the violet towards the red. Is there, then, nothing in the above remarks of Paracelsus?

When we dip a piece of blue litmus paper in an acid it turns red; dip this red paper in an alkaline solution and it turns blue—another hint that Paracelsus' division of colors is correct or philosophical.

According to electro-chemistry, oxygen and all acids are electro-negative, while hydrogen and all bases are electro-positive. Along with oxygen on the electro-negative side we have fluorine, chlorine, bromine, iodine, sulphur, etc.; on the electro-positive side, hydrogen, potassium, lithium, sodium, calcium, barium, magnesium, zinc, etc. Grabau (*Pharmakodynamik*, 1837) characterizes the action of acids as being an arterial contraction (Dr. Ridge says they are tonics), while the action of the alkalies is to liquefy; Glauber salt, saltpeter, carbonate of potash, added to the freshly drawn blood, retard its coagulation; alkalies excite the secretions, lower the blood tension, bring about mucous flux, pallor of tissues, diminish the animal heat, and cause chilliness, cold swellings and tumors, according to

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\* Here are two sweet morsels for the advocates of scientific medicine to roll under their tongues; they are taken from his Scholia: "Nullo modo curatur morbus per contraria, sed quodlibet suo simili," and, "Karena (a dosis) est rigesima quarta pars guttae." Paracelsus is acknowledged as the father of scientific medicine; he exploded "Galenism" in his days.

A. Espanet (*Hom. Mat. Med.*), while acids, he continues, cause erethism and a higher tension, dry up the tissues by some kind of evaporation, and augment the animal heat. Some salts, like iodide of potassium, natrum muriaticum, etc., are what Frenchmen call *fondants* (*fondre*, to melt), i.e., tumors will melt away under their prolonged action.

Dr. von Grauvogl, in his *Lehrbuch der Homœopathie*, explains the difference of action between aconite and belladonna by saying that bellad. acts on the blood-cells, while aconite acts on the serum. It may here be remarked that the flowers of aconite are blue, while those of belladonna are purplish.

Grauvogl has attempted to classify remedies and diseases according to three types; but to me, at least, his diagnostics of the three different constitutions seem very uncertain, except that of the *hydrogenoid* constitution, which may as well be called the *alkaline* constitution, since the alkalies, as drugs, are potent remedies in this condition. But why there should be just *three* different constitutions is not clear to me; why not four or two?

There are certain relations between the atomic weights of the chemical elements, which show that all elements can be arranged according to a certain classification. For instance, the atomic weight of oxygen is 16, of sulphur 32, of copper 63, of antimony 120; that is, each one has the exact or nearly exact double atomic weight of the preceding one. According to Grauvogl, oxygen, sulphur and copper are producers of ozone, and as such very useful in all those diseases caused by a retention of carbon and nitrogen in the organism. Sulphur and copper are often used in skin diseases; and Grabau says that antimony receives, through the addition of sulphur, a more direct curative power in skin diseases than when uncombined as antimony alone.

The atomic weight of nitrogen is 14, that of silicon 28, and of iron 56; these three are exactly the double, one of the other. Now, a solution of green vitriol (ferrous sulphate) will take up forty times more nitrogen than pure water will, according to Grauvogl.

All these facts are certainly of great importance, but so far we lack "das geistige Band," as Goethe said, to connect them together and draw some practical results.

To close this essay, I will here introduce an important principle, discovered by a French therapist, Rabuteau, the author of an excellent (allopathic) *materia medica*:

"By comparing the physiological energy or the toxicity of metals whose atomic weight is high, such as lead, mercury, with that of metals whose atomic weight is low, such as sodium and magnesium, we observe considerable differences: the salts of the first named are dangerous even in small doses, while those of the last named can be introduced into the organism with impunity in considerable doses. These differences of action are related to the different atomic weights, viz.:

"The metals are the more active (or poisonous) the higher their atomic weight.

"Thus the salts of sodium (at. w. 23) are much less active than those of potassium (at. w. 39), and those of calcium (at. w. 40) than those of barium (at. w. 139). And since the atomic weights of the elements are in inverse proportion to their specific heats, we may thus express this *law of toxicity*:

"Metals are the more active (poisonous) the lower their specific heats are.

"This law is true for all metals and metalloids except for the nonatomic metalloids."

This law, of course, is of great importance for the posology in massive doses. And it will explain why the action of the so-called *antipsorics* is of such an active and lasting nature, since iodine, gold, mercury, etc., have all a high atomic weight. The same remark applies to the so-called *alternatives* of the allopathic school.

It is hoped that these few remarks may one day be developed into a correct system, and that the connection which exists between the natural sciences will become clearer and clearer, and bring about the much-desired solution of the much-vexed medical question, and make it a science.

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**PULSATILLA IN CHRONIC HEADACHE.**—Dr. Bryce records the case of a woman over 60 years old who had suffered from attacks of severe headache for 30 years. The pain was over the vertex, and, if it came on when she was in a hot room, she was obliged to go out into cold air to relieve it. It was much more frequent in hot, confined air, and rarely or never occurred out of doors. These being the only indications, *pulsatilla* 30 was ordered, which cured in a few weeks, and the headache has not been felt since.—*Monthly Hom. Review*, June 1, 1896.

## SOME POINTS ABOUT NIGHT SWEATS, AND SOMETHING SPECIAL ABOUT SILICA.

BY EDWARD R. SNADER, M.D., PHILADELPHIA.

(Read before the West Jersey Homœopathic Medical Society.)

ABNORMAL sweats occur in the course of many maladies, and belong among the symptomatic manifestations of diverse diseases—diverse in the differing clinical pictures presented by the *ensemble* of symptoms, and diverse as to the varied pathological conditions accompanying the sweatings. It is not my purpose to consider at length all the conditions clinically characterized by the occurrence of abnormal watery exudations from the cutaneous surfaces. But I do purpose to devote a little time to the consideration of sweating as it occurs in the progress of that malign malady, phthisis pulmonalis. In typical cases of consumption of the lungs, at some period of the evolution of disease, abnormal sweats almost certainly appear. In fact, night sweats are placed among the cardinal symptoms of the affection, and I know of no other chronic disease of which sweats are more prominently symptomatic than in phthisis.

The sweats occurring in the course of a lung malady may be diurnal or nocturnal. It is seldom, however, that the ordinary sweats transpiring during the waking hours require special control. The night perspirations at times dominate the whole case and require specific therapeutic attention.

We know very little, indeed, of the exact rationale of the production of sweats—of the evolution in the mechanics of the organism, that throws upon the skin's surface such enormous secretions or excretions. It is probably through the implication of the vasomotor system that sweats occur. Undoubtedly circulatory changes and cutaneous relaxation play an important part in causing sweats; but as yet our knowledge is insufficient to exactly "make the punishment fit the crime." Much, therefore, as to mechanism is theory. But, practically, we know one thing, and know it well, and that is that sweats clinically are a representative of bodily *weakness* as they occur in the progress of phthisis pulmonalis. They are not eliminative of a blood-contaminator, as has been theorized concerning articular rheu-

matism; not critical, as at the end of the reign of the pneumococcus in croupous pneumonia; not conservative of the circulatory and thermic balance, as during the progress of prolonged or violent exercise. No; night sweats as they appear in phthisis pulmonalis are an unmitigated evil—a systemic declaration of weakness. Nor do these nocturnal wettings indicate necessarily the subsidence of fever. Sweats, and bad ones, too, are often found without any thermic rise; and, if associated with fever, they bear no proportion whatever to the height of the column of mercury in your clinical thermometer. These sweats appear early, in between stages, and late. They are sometimes prominent in the incipiency of lung implication, when the cheek is still warm with red blood, when the form is still plump, when the step is still elastic, and when the tell-tale hack, hack, hack is, according to the patient, the remnant of a "little cold they took last week." They are sometimes overwhelming, sometimes slight, and sometimes absent, when the patient is worn and wasted to osseous angles, when his air-bags, his life-preservers on the sea of life, are rid-dled with holes, and that horrible hollow cough is heard, while death is in the chamber waiting the end, and the patient tells you, with a hoarse, ghoulish whisper, "Doctor, I know I'll be better as soon as the weather improves."

Night sweats may be present in all stages, but are constant in none. They do not of necessity come at any special stage; but are more frequently found when the lung tissue is breaking down rapidly, sometimes ceasing when a cavity is formed and emptied, recurring again when the disintegrating process is re-newed at another portion of the lung. While more frequent under such circumstances, I must insist that night sweats be not interpreted as always meaning active lung break-down. They often mean pulmonary wreckage, but not always. The physical signs must be depended upon to determine whether the sweats have or have not this dire significance.

Briefly, then, sweats indicate weakness—systemic weakness. Night perspirations are danger signals. Sweats as they take place in phthisis may mean weakness, may mean the precedent presence of fever, may mean systemic intoxication with the products of the febrile process, may mean poisoning of the organism with the toxic detritus of the tubercle bacillus, may

mean a new invasion of lung tissue, may mean systemic exhaustion after a skirmish with a suppurative process has been fought and lost, may mean vasomotor paresis from a concomitant circulatory disorder, may mean connective tissue relaxation in the cutaneous sphere in consequence of associated muscular weakness, may mean congenital or acquired peripheral irritability, may mean the acquisition or subsidence of a secondary pleurisy, may mean the crisis of a complicating localized croupous pneumonia, may mean a bad bodily habit persisting after the originating cause has ceased operation—night sweats may mean any of these conditions or many of them. Several causes may, of course, coexist.

It is seldom, indeed, possible to determine with exactness the principal operating cause. Sometimes, by an exceedingly close analysis of symptoms and recourse to physical exploration, a dominating cause can be determined, and when the underlying source of sweat can be definitely discovered, the therapeutic control of the symptom is much easier than it ordinarily is. Of all causes lung suppuration is the most frequently the readiest of determination.

Night sweats, recurring in the course of phthisis, in my experience, seldom require special medication. They require to be controlled, it is true; but I mean that the drug you select to cover the general symptoms of the patient, if it is of any service to him at all, as a rule, controls the sweats while it is ameliorating the other phenomena of the disease.

There is, to my mind, much therapeutic nonsense extant regarding night sweats and their treatment. Many physicians, as a routine practice, use a special medicine, outside of the one selected for the case in general, for the cure of the sweats. In a large majority of cases this is unnecessary.

I see a great number of cases of phthisis who have among their symptoms sweat, who, in my opinion, need no "sweat medicine." The medicine selected generally removes that symptom. In fact, as a rule, that is one of the first symptoms that shows the beneficent action of the chosen remedy.

But, there are night sweats and night sweats. Occasionally night sweats will dominate an entire case; it will be the most prominent, the most annoying, the most unyielding symptom of the whole group presented by the patient.

About one patient in forty presents these terrific, overwhelming drenchings, which leave him so weak and exhausted that he believes his whole trouble is "sweats." And you, too, soon come to the conclusion that if you are to be of any service whatever to your sufferer, you must control that symptom at all hazards. You do not care, in your extremity, very much how you get the best of the night sweat, only so you can do so, and thereby help your patient, giving him a chance for your other medicines to act, and secure all the other side but necessary benefits that arise from the amelioration of the sweat. I have been guilty of alternation, and several other so-called stupid things also, in my desperate efforts to relieve these patients from their auto-evolved baths. I am not at all ashamed to make this confession; because in quite a number of instances "I got there," to use a very inelegant but expressive vulgarism. Besides, this confession may make many of you feel easier in the knowledge that there are other sinners against what some of our friends tell is the ONLY way to practice, according to what they are pleased to call their own peculiar pet definition (exclusive definition, all rights reserved) of homœopathy. I prefer my own definition as to what is and what is not an homœopathic prescription and what is an homœopathic cure. Despite what may be termed mongrelism, I shall present the statistics of some ameliorations by what I am reasonably sure are homœopathic means. I will hold to that view, at any rate, until some one convinces me otherwise. I want to say, that I do not always alternate; in fact, that procedure is infrequent with me; but when I do alternate I have very good reasons for so doing.

In my endeavors to control excessive, exhausting, dominating, persistent night sweats occurring during the progress of phthisis, I have used quite a number of remedies, both old and new school.

Agaricine I have not found sufficiently useful to continue; ergot has been of very little service, and sometimes of positive detriment.

Atropia I have not employed in the recommended doses, and therefore can neither commend nor condemn, although belladonna, in our own dosage, has often helped me. I have not, so far, made use of any local applications save, very exception-

ally, alcohol baths in the very last stages, and then more for their general effects than for any special control secured over the sweats.

Among the homœopathic remedies, in addition to belladonna, already mentioned, I have had good results with sulphuric acid, sambucus, iodide of arsenic, arsenic, iodine, bryonia, baptisia, calcarea carbonica, calcarea phosphorica, kali carbonica, china, hepar, sepia, stannum, sulphur, phosphorus, phosphoric acid, pulsatilla, nux vomica, jaborandi, ferrum, benzoic acid, chamomilla, rhus toxicodendron, and others. The iodide of arsenic, china, sulphuric acid, sambucus, and the calcareas have been the most frequently used; but the medicine that is most effective in my hands is silica. Silica more often than any other drug controls exhausting night sweats.

Let me present you, in tabulated form, a sketch of the cases on my record books in the Heart and Lung Department of Hahnemann Medical College, Philadelphia, covering a period of nearly, if not quite, five years, in which the drug was used to control not ordinary, but extraordinary, night sweats. It was prescribed not only in phthisis pulmonalis, but also in other disorders characterized by exhausting nocturnal perspirations. Very often the drug was given only in the evening, *i.e.*, in two doses, at 6 and 8 P.M.

This statement embraces 62 cases. In 48 cases the night sweats were stopped, 18 cases were improved and 6 were not improved. I consider that these rather meagre statistics justify me in considering that in silica I have found a reasonably reliable medicine for the assuaging of severe night sweats. Silica approaches about as nearly a specific as any sensible physician, in the present state of our knowledge concerning drug action, has a right to expect. Its happy effects certainly justify me in holding the medicine in high respect, and in presenting it to you for consideration and confirmation. In making a prescription of silica sometimes specific symptoms calling for it were present, but far oftener the drug was given empirically, that is, without reference to other symptoms than the presence of sweats that would not yield to other drugs, or to the one presumably covering the totality of the clinical phenomena.

It will be noted that in the majority of instances silica was prescribed in a high potency. Ordinarily I do not prescribe

DISEASE.	DOSE.	EARLIEST TIME OF AMELIORAT'N.	RESULT.
Phthisis pulmonalis.....	30· fol- lowed by 200	Unknown.	Relief.
Broncho-pneumonia.....	30·	"	Relief.
Phthisis pulmonalis.....	30·	Did not return.	No relief after six days.
Bronchitis.....	30·	.....	Relief (partial).
Phthisis pulmonalis.....	30·	Five days.	Relief.
" "	30·	.....	No record of result.
" " cav.....	30	.....	No relief; followed by 3x, which relieved.
" "	30	.....	No relief; followed by 3x, which relieved.
" "	30	.....	Relief.
" "	30	.....	Agaricus had been prescribed five days before without relief.
" "	30	.....	Relief; a dose at 6 and 8 P.M.
" "	30	.....	Relief.
" "	30	.....	Relief.
" "	30	.....	No relief after six days; followed by 6x, which relieved in 2 days.
" "	6	Two days.	Relief.
Fatty degeneration of heart.....	8x	Three days.	Partial relief.
Fibroid phthials.....	30x	.....	Relief.
Emphysema.....	30	.....	No relief after seven days; followed by 30x, which relieved.
Fatty heart.....	3x	.....	No relief.
Phthisis pulmonalis.....	30x	.....	Relief.
" "	30·	.....	Relief.
" " cav.....	30x	Two days.	Relief.
Gastric ulcer.....	30x	.....	Relief; given in alternation with nitric acid. Sweats not relieved until silica was prescribed; sweat about neck and shoulders.
Phthisis pulmonalis.....	30·	Four days.	Relief.
" "	200	.....	No relief until 6x was prescribed.
" "	6x	Two days.	Relief.
" "	6·	Three days.	Relief.
" "	6x	Two days.	Relief.
" " tuberc'lr.	200	Four days.	Relief; returned on Nov. 7th and were then controlled in 1 day.
" "	6x	Three days.	Relief.
" "	6·	Two days.	Relief.
" "	6·	.....	Relief.
" "	6·	Three days.	Relief.
" "	6·	Two days.	Relief.
" "	6x	Three days.	Relief.
" "	6·	.....	Relief.
" "	6·	Two days.	Relief.
" "	6·	Three days.	Relief.
" "	6·	Two days.	Relief.
" "	30·	.....	Relief.
" "	6x	Three days.	Partial relief; ars. iod. stopped entirely after three days.
" " cav.....	6x	Four days.	Continued improvement after second day.
" " "	6x	.....	Improved.
Bronchitis, subacute.....	6x	.....	Partial relief.
Phthisis pulmonalis.....	6·	One day.	Relief.
Adv. valvular heart disease.....	12·	.....	No relief; ars. iod. relieved.
Phthisis pulmonalis.....	6x	Three days.	Improved.
" "	6x	Four days.	Improved.
Pneumonia, catarrhal.....	6·	.....	Improved.
Phthisis pulmonalis.....	30·	Five days.	Relief.
Bronchitis.....	30·	Seven days.	Improved.
Fibroid phthials.....	6·	Four days.	Improved.
Lobar pneumonia.....	30	.....	Improved.
Phthisis pulmonalis.....	6·	.....	No relief.
" "	6·	.....	No relief.
" "	6·	.....	Relieved.
La grippe.....	6·	.....	Relieved.
Phthisis pulmonalis.....	6·	.....	Relief.
" "	6·	.....	No relief.
" "	6·	Two days.	Relief.

62 cases; 48 stopped, 18 improved, 6 not improved.  
Prescribed in 7 cases without record of symptoms.

drugs in the high attenuations, but I make a marked exception in favor of silica. I do not believe that theorizing will settle the potency question ; nor do I believe that the microscope can define and settle the fact of the presence or absence of a medicinal substance. I pin my faith to clinical experience. Clinical experience alone can deify or damn a medicine, but not theory or the microscope. It is a matter of the profoundest indifference to me whether I cure with a barrel of the fluid extract or a sky-scraping essence of moonshine, provided I cure in the speediest and mildest way possible with the minimum curative dose, always premising that the patient is benefited only and in no way damaged by the treatment.

Silica has produced nothing but good results so far as I have observed. You may ask me : How does this medicine, regarded as practically inert, produce its effects ? My reply is : I do not know. My observations go to show, although they have not yet received sufficient confirmation to make my belief absolutely stable, that silica profoundly affects the nervous system, and conjointly and particularly the sympathetic nervous system. Unquestionably there is enough proof in the pathogenesis to admit of the presumption that it acts decidedly upon the vasomotors. It is probable that it produces its results by its tonic action upon the vessel-controlling system. This is all theory, however; in the absence of more data it is the best I can do. But the practical fact—and as a physician I am in search of practical facts—it rapidly ameliorates and often causes the entire disappearance of severe, exhausting night sweats. Let it be understood, however, that by the cure of sweats I do not mean, of necessity, their total disappearance, but in the vast majority of cases the sweatings cease to dominate the case, and cease to annoy the patient; in other words, the sweatings are under control. I am satisfied that silica does infinitely better than the crock of water the genial old lady places under the sufferer's bed—and you know how wonderfully efficacious that procedure is found to be by the all-wise laity.

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A POINT IN ELECTRIC EPILATION.—Dr. Dubreuilh recommends in practicing epilation by electricity to cut off the hairs closely one or two weeks before. Those hairs that then grow are alive and may be epilated ; the others are dead and may be extracted with forceps. Any hairs developing later may then be epilated.—*Weiner Medizinische Presse*, No. 23, 1896.

## EDITORIAL.

## REMOVAL.

THE office of the HAHNEMANNIAN MONTHLY has been removed from 419 Pine Street to 1402 Spruce Street, Philadelphia, to which address all future communications, exchanges, books for reviews, etc., should be sent.

## THE GERM THEORY OF DISEASE.

WE can accept this theory in its universal application only as a theory, or rather as an hypothesis, a working hypothesis, the correctness of which it will take many years of strict scientific investigation to confirm. We can regard it as nothing else if we compare the small number of diseases in which the presence of a characteristic germ has been demonstrated with the many in which the search has, as yet, been unsuccessful. Even when such germ has been found, there remains much to be done before it can be accepted as the causative factor, since the possibility of its being either the result or a mere concomitant always demands refutation.

The theory, by reason of its plausibility and simplicity, has met with recognition and acceptance far beyond the proof of its truth which it has been able to offer. In its present condition we think it has a tendency to work injuriously both upon our theory and our practice.

In other sciences a working hypothesis is applied to known facts in order to furnish the simplest and most thinkable explanation of them. The strictest precautions are taken that the facts are not distorted nor their most natural interpretation set aside in order to make way for the application of the hypothesis. Observation and experience are not lightly disregarded in order that the hypothesis may be verified. All of these things, we think, have been and are being done in the case of this, as yet, unproved theory. We do not mean to deny that it may eventually be demonstrated to be true, but in a more re-

stricted sense than is at present claimed by many of its advocates.

It has already modified and limited, in a very great measure, the earlier views of heredity, while it has enlarged to an equal if not greater extent the sphere of infection and multiplied the number of so-called local diseases.

The caution which must be exercised in estimating the value of undoubted facts is well illustrated in the results of Senator's observations in 700 cases of diabetes mellitus. He found among these nine instances of man and wife suffering from the disease. Oppler and Kulz had observed ten instances in 900 cases. This could, and no doubt would, have been wrested by some to establish the transmissibility of the disease from husband to wife, or *vice versa*, but Senator very correctly points out that if from these nine instances we exclude those in which a family history of the disease could be traced, and those where the same antecedents were apparent, the occurrence of the remaining could well be regarded as an accidental coincidence.

The germ theory once adopted in its universality, we are too prone, even in unproved cases, to underestimate the facts which point to other influences at work in the production of disease.

Again, in practice, with this theory constantly dominant, our efforts are directed too often to the discovery of a germicide to the exclusion or undervaluation of therapeutic measures suggested by other considerations. This tendency is particularly noticeable in surgery, where we so often find an almost total neglect of remedies which might act as adjuvants to the purely mechanical and germicidal treatment by their action on the system at large.

While these effects are more evident in the practice of the allopathic school, and meet us on almost every page of its journals, they are not wanting even among the homœopaths. We are being led to specialize the organs too much, to localize too many diseases, and to overlook the necessary substratum of all diseased action, and hence to fail to obtain from our *materia medica* the means of rendering germs innocuous.

If we accept our law of cure, and if that law is absolute, then must the *similimum* include and cover the apparent effects of all factors of disease, hereditary, constitutional and accessory.

## INDIVIDUAL JUDGMENT.

AN interesting case was recently decided in Saxony, to the teachings of which we will do well to listen.

A certain physician, a believer in the dangerous character of alcohol in all diseases, came to treat a patient suffering with blood-poisoning, and who had for eight days been receiving large doses of alcohol and quinine. Acting according to his convictions, the physician, Dr. Hirschfeld, withheld the alcohol. The patient died at the end of thirty-six hours, and Dr. Hirschfeld was accused of having accelerated his death by withdrawing his accustomed stimulant.

The question was referred by the State Attorney to the General Medical Council of Saxony to procure an authoritative opinion. The council called attention to the great change of medical opinion as to the therapeutic value of alcohol, and, what we here particularly wish to note, upheld the principle that it is inadmissible to put any limit to the exercise of the individual judgment of the physician. A verdict of acquittal followed, and the costs of the prosecution were put upon the state.

If on the Continent, and particularly in Germany, where paternalism in government is the acknowledged principle, the right of individual judgment in matters medical is upheld and defended in the highest tribunal in the land, how much more should it be undisputed in this "sweet land of liberty?" And yet do we not see insidiously creeping in many an octopus-like bit of legislation which is either directly or by inference subversive of this principle? What is the true bearing of the prevalent practice of having county and State societies pass judgment by resolution upon some point of hygiene or medical practice? Is not such opinion regarded as more or less binding upon the members of the society, and even upon the members of the whole profession, regardless entirely of the views of the rest, who either were not present or who were in the minority?

We all know how such things are done, how they originate, and how they are generally carried through. They are, we think, essentially mischievous in character. Being frequently expressions merely of individual opinion, and seldom prompted by any public urgency, they give to a subject exaggerated im-

portance, and insensibly lead to the erroneous idea that in such matters of belief the majority is to rule, as it does in matters of polity.

This is but one of a number of practices which, seemingly innocent in themselves and even, in some cases, of apparent utility in guiding public opinion, tend inevitably to undermine the sense of individual independence of judgment, to which every physician should hold fast, together with his sense of personal responsibility. Each man is a law unto himself, and must act according to his own convictions.

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#### THE NEW YORK AND PENNSYLVANIA MEETINGS.

THE recent meetings of the Pennsylvania and New York State Societies, held in the cities of Philadelphia and Rochester were unusually successful, the attendance in both instances being exceptionally large and the character of the executive and scientific work was unexcelled.

The New York meeting, under the able and enthusiastic leadership of Edwin H. Wolcott, M.D., of Rochester, the President of the State Society, together with the abundant hospitality of the local physicians, was the most successful semi-annual meeting that society has yet attained, and a standard has been established that other localities are going to find hard to equal. While but little business is ever attempted at the semi-annual meetings of this society, two very important movements were inaugurated. First, steps were taken to reform the method of expert medical testimony in the State, and secondly, and of even greater importance, was the formation of a "State Legislative League," the object being the organization of the homœopathic physicians and laymen of the State of New York into a league to protect the interests of the school in all legislative matters.

The Pennsylvania State Society had the most successful meeting of its history, the physicians in attendance at its various sessions numbering between three and four hundred. The special feature of the 1896 meeting was the centennial of the promulgation of Homœopathy by Hahnemann, and it was ably presented in various addresses and at the banquet given in honor of the occasion by the physicians of Philadelphia. An

able committee of thirty of Philadelphia's most distinguished physicians, under the leadership of the indefatigable Dr. Keim, made special preparations to give the meeting an appropriately distinctive character and to brilliantly entertain the visiting members and the guests of the society; how well they succeeded will be left to the testimony of those in attendance. The Secretary, Dr. Gramm, presented a programme of eighty-three papers which proved to be an embarrassment of riches which was only overcome by reading many interesting and valuable papers by title. The discussions, while necessarily limited, were spirited and to the point, and developed much information of value to those in attendance. In the legislative and executive departments of the society a great deal was accomplished for the benefit of the society. The officers of the society were directed to take the necessary steps to have the society incorporated under the laws of the Commonwealth.

The Committee on Legislation was authorized and instructed to favor the enactment of laws providing for the appointment of medical experts by the courts as a substitute for the methods now in vogue, with a view to securing more able as well as more trustworthy aid in medical proceedings, and the same committee was recommended to again make a vigorous and general effort to secure State hospital care and homœopathic treatment for the insane of that large class of citizens who employ the homœopathic method of medical treatment, on the same basis as this care and treatment are now provided for other citizens of this commonwealth.

A pleasing and gratifying feature of the three days' meeting was the presence of a large number of distinguished visiting confrères, who were the guests of the society and whose presence added much to the success of the meeting. Among this number were Dean Helmuth, of the New York College; Dr. J. B. Gregg Custis, of Washington, the president-elect of the American Institute of Homeopathy; Dr. Edwin H. Wolcott, Rochester, President of the New York State Society; Dr. J. Paul Lukins, Wilmington, President of the Delaware State Society; Dr. M. F. Middleton, President of the New Jersey State Society; Dr. A. B. Norton, New York, President of the Otological, Ophthalmological and Laryngological Society; Dr. Eugene H. Porter, Editor of the *North American Journal of Homœo-*

*pathy*, Drs. William Tod Helmuth, Jr., and George W. Roberts, of New York city; Drs. William R. King and Charles B. Gilbert, Washington, D. C.; Dr. Peter Cooper, Wilmington, Del., and a large delegation of New Jersey physicians.

Meetings of the character of these held at Rochester and Philadelphia aid greatly in furthering medical science and particularly homœopathic therapeutics, and the commingling of physicians of near-by States is to be encouraged on these occasions, for it knits close the bonds of fellowship and there is a gathering from each other of force and faith that is mutually beneficial. These two meetings will go on record as desirable ones to be repeated and equalled in the future.

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CHARLES E. FISHER, M.D., of Chicago, the editor of the *Medical Century*, is seriously ill with typhoid fever. Until Dr. Fisher's convalescence is completely established, Dr. W. A. Smith, of the same city, will have entire charge of the editorial department of the *Century*.

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**Hæmoglobinuric Bilious Fever.**—Dr. Kanellis (Greece) states that hæmoglobinuric bilious fever is produced by the double influence of an old malarial infection and a peculiar susceptibility to atmospheric changes in hot climates. In Greece, where the mortality of this disease is 22.4 per cent., it has been noted that it may be dependent upon quinine, as Tomaselli and many other Italian physicians have taught. Besides this, it is admitted that hæmoglobinuria may be due to cold alone. This form of bilious fever affects males principally between the ages of 7 and 45. As to its pathogenesis, the destruction of the red-blood corpuscles would explain the color of the urine and the icteric appearance of the mucous membranes. If bile pigments be detected in the urine with hæmoglobin, then the icterus is of hepatic origin. There are other varieties of melanuric fevers. For example, there is one where there is only pure hæmoglobin in the urine; in another, hæmoglobin mixed with bile-coloring matters; a third form in which the urine contains either hæmoglobin alone or mixed with bile and a certain number of red corpuscles. Finally, there is a form where these red corpuscles are abundant, evidently due to a peculiar individual susceptibility to hemorrhage. He advises the use of quinine in large doses, which is to be suspended as soon as anuria sets in.—*La Settimana Medica*, No. 18, 1896. [Prof. Osler (*ibid*) describes these varieties under hæmorrhagic forms of malarial fever: "In all the severe types of malarial infection, especially if persistent, hemorrhage may occur from the mucous membranes. An important form is the malarial hæmaturia, which in some instances assumes a very malignant type. Paroxysms of ague may precede the attack, but in many cases called malarial hæmaturia, there is no febrile paroxysm. The condition is usually hæmoglobinuria, though blood corpuscles are present also. In severe cases there is bleeding from the mucous membranes. Jaundice is present, but to a variable extent, and is hematogenous, due to destruction of the red blood corpuscles. Malarial hematuria occurs in epidemic form in many regions of the Southern States, and in some seasons proves very fatal."—Edu.]

## GLEANINGS.

## GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D., AND FRANK H. PRITCHARD, M.D.

**SALOPHEN IN RHEUMATISM.**—When it is considered how universal a disease is rheumatism in its various manifestations, and how long it has existed as one of the plagues of mankind, it is remarkable that there should be only so small a list of really efficient remedies at the command of the physician. The salicylates at one time were thought to approach more closely than anything else to being specifics for rheumatism, and their introduction into therapeutics was certainly a great advance on previous forms of medication. But the fact remains that their use is not infrequently fraught with disappointment. Some authors have gone so far as to claim that they sometimes do more mischief than the disease itself on account of their weakening effect on the heart and nervous system. Be this as it may, their use is quite often followed by prolonged impairment of the digestive functions in consequence of their irritating effects on the gastric mucous membrane. Renal irritation has also been observed. All these disadvantages of the salicylates are obviated in a derivative of salicylic acid known as salophen, which while possessed of marked antirheumatic power is perfectly innocuous. Owing to the fact that this drug is not decomposed until it reaches the intestinal canal it will not disturb the gastric functions, which is a point alone of the utmost importance.

**A CLINICAL STUDY OF HYSTERIC ÖDEMA.**—Dr. Soyez (Paris) has made a clinical study of hysterical œdema, a disease which was noticed by Sydenham and fully described by Charcot and his pupils. Clinically, there are four chief forms:

1. White œdema, which often supervenes upon contractures and paralysis. [Prof. A. Pitres (*Leçons Cliniques Sur L'Hystérie et L'Hypnotisme*, vol. I., p. 396; Paris, 1891) speaks of this variety, though less common than atrophy, as a possible accompanying sign of contractures of hysterical origin. It is sometimes white and soft as in cachectic œdema though it may be observed as an apparent inflammatory œdema with a phlegmonous appearance.—Eds.]

2. Blue œdema, which is associated with local lowering of temperature [Drs. P. Blocq and J. Onanoff (*Sémiologie et Diagnostic Des Maladies Nerveuses*; Pp. 447; Paris, 1892) state that this variety most frequently is noticed upon the lower extremities as an accompaniment of paralysis or contracture; it is a hard œdema which cannot be dented with the finger, and though the skin may be normal in color it is generally blue. The essential œdemas resemble somewhat, but it is rather that of Basedow's disease and acute angio-neuritic œdema. They go on to say that this bluish tint of the skin may appear before the œdema itself or not disappear simultaneously. It is accompanied by sensations of numbness, formication and a decrease of local temperature even to three degrees below normal. It usually commences with the motor disturbance with which it is associated and undergoes changes with it. Thus it may suddenly disappear after an emotion. It may be reproduced by hypnotic suggestion.—Eds.]

3. Hysterical arthralgia, which may attack any of the large joints. [Prof. Osler (*Practice of Medicine*, p. 974, 1892) states, that to Sir Benjamin Brodie and Sir James Y. Paget we owe the recognition of these extraordinary manifestations of hysteria. Perhaps no single affection has brought more discredit upon the profession, for the cases are very refractory, and finally fall into the hands of a charlatan or faith-healer, under whose touch the disease may disappear at once. Usually it affects the knee or hip and may follow a trifling injury. The joint is fixed, sensitive and swollen. The surface may be cool, but sometimes the local surface-temperature is increased. To the touch it may be very sensitive and movement causes great pain. In protracted cases the muscles about the joint are

somewhat wasted, and in consequence it looks larger. The pains are often nocturnal, at which time the local temperature may be much increased. While as a rule neuro-mimetic joints yield to proper management, there are interesting instances in the literature, in which organic change has succeeded the functional disturbance. In the remarkable case reported in Weir Mitchell's lectures, the hysterical features were pronounced, and, on account of the chronicity, the disease of the joint was considered organic by such an authority as Billroth. Sands operated and found the joint-surfaces normal, and the thickening to be due to non-tuberculous inflammatory products outside the capsule.—[Eps.]

4. Hysterical breast [or irritable breast of the English writers, a variety of hysterical hyperalgesia.—Eps.] Gilles de la Tourette has given a masterly description of this affection, which disease is often unrecognized and thus exposes one to uncalled for operations especially where ulcerations have formed.

Treatment is chiefly prophylactic. The diagnosis depends upon the variety. The white form will not pit under the finger, thus distinguishing it from œdema of cardiac, renal and cachectic œdema. It cannot be confounded with pseudolipomatosis nor with the lipomatous affection described by Mathieu, which are noted in advanced age, while hysteria is an affection of youth. Raynaud's disease is distinguished from the blue variety in that it usually is bilateral. In arthralgia one should look for hysterical stigmata; this also holds good in the hysterical breast, which is often confused with abscess or cancer of the mamma. These will frequently decide in case an operation is to be done in this form where operative interference is both useless and injurious.—*Rivista Clinica E Terapeutica*, No. 3, 1896.

**A CASE OF RECOVERY AFTER TUBERCULOUS MENINGITIS.**—Dr. H. A Janssen (Holland) calls attention to the varying views of writers with regard to the possibility of a recovery in tuberculous meningitis. While Strümpell, Eichhorst and Henoch are very sceptical, others, as Coindet, Abercrombie, Bouchut and West, have thought to have noticed recoveries. Cerebro-spinal meningitis, cerebral gumma (Fournier) and certain forms of poisoning may give rise to the same symptoms. Unfortunately, the pathologico-anatomical proof is lacking. The writer has collected seven such confirmed cases from the literature and adds an eighth from his practice. Rilliet observed a violent tuberculous meningitis in a boy of 5 years who recovered in forty days. Five years after he had a second attack and died. The necropsy revealed, besides fresh eruption of tubercles at the region of the fossa Sylvii and the convexity of the brain, old, yellow tuberculous masses and opaque, milk-white patches in the pia mater. Pulitzer records a very similar case, where a recurrence three years after gave a necropsic finding of old fibrous changes, remains of a former basilar exudate, together with fresh eruption of tubercles. Carrington, Biedert and Leube have each reported a case of recovery from tuberculous meningitis. Schwalbe has reported two cases where the children died a year after diphtheria and where the necropsy presented undoubted evidence of a former tuberculous exudate. Finally, Freyhan, in 1895, has published a case followed by recovery, where the diagnosis was confirmed by the detection of tubercle bacilli in the fluid withdrawn by lumbar puncture.

The writer's case was that of a corporal, 19 years of age, who, in May, 1892, entered the hospital with symptoms of tuberculous meningitis: intense headache, vomiting, constipation, pulse forty-two, convergent strabismus, dilated pupils, rigidity of the neck, slight opisthotonus, tâches cérébrales, contracture of the left knee and unconsciousness. Under the use of heroic doses of iodide of potash, beginning with 8.0 *per diem* and gradually increasing to 40.0 in the day, so that he received in all 950.0 of the iodide—he recovered in six weeks. Three years after he was seized with florid phthisis, and died in four months. At the necropsy, on both sides of the longitudinal sinus and in both fossae Sylvii, as well as around the chiasm, there were discovered yellowish masses, which were found to consist of numerous and greatly degenerated tubercles. No bacilli were to be detected. Scattered over the brain were milky plaques, and here the pia mater and arachnoid were adherent to the surface of the cortex. He attributes the recovery to the large doses of iodide of potash.—*Hospitalstidende*, No. 16, 1896. [Professor Goodno (*Practice of Medicine*, vol. i., p. 355) admits the possibility of recovery, though stating the decidedly gloomy outlook. He rightly places great dependence upon iodoform in the treatment of the disease. I have frequently seen reports of cases of poisoning by the drug where, from the description, one would diagnose meningitis. The close similarity has often been pointed out.

The professor advises the use of the drug internally, while others place greater reliance upon a salve applied to the head. Osler (*ibid.*) states that he never has observed a recovery to follow in an undoubted case, nor has he seen post-mortem evidence of past disease of this nature.—Eds.]

**ACUTE LEUCÆMIA.**—Dr. A. Fraenkel has observed during the past five years nine cases of this disease which was described by Ebstein in 1889 as acute leucæmia, and which differs from the chronic form by its acute beginning, its immediate severe symptoms and its relatively rapid course of few weeks.

The affection attacks both sexes, at all ages, though preferably young men. Setting in with general weakness, after previous good health, vertigo and palpitation then follow, with the characteristic diathesis, associated with haemorrhages into the skin and mucous membranes. There may also be stitching pains in the spleen and limbs, with pains in the joints, so that in one of his cases a rheumatic fever was diagnosed. Haemorrhages into the retina are nearly always present, while, though rarer, those into other organs, and particularly into the brain are of special interest. *As a rule, there is very great anæmia*, yet this sign may be absent. The lymphatic glands are enlarged, though not prominently so. *The enlarged spleen* may be absent, though it usually is present. Occasionally the liver is increased in size. *Increase of temperature* is observed, but there is no decided temperature curve. As death draws near, there may be sopor and delirium. Microscopically, the marrow of the bones was always found affected, of a dark red and haemorrhagic appearance, and occasionally grayish red and lymphomatous, with yellowish green points. The duration of the disease varies from three to nine weeks, though it may last sixteen weeks. All his cases ended fatally. As predisposing causes, he mentions great anæmia, pregnancy and, finally, certain infectious diseases, and above all, influenza. The blood-changes he has found to differ from those of chronic leucæmia, for the increase of white blood-corpuscles appeared to be due to the augmentation of the mononuclear elements alone.—*Hospitalistide*, No. 25, 1896. [Osler (*Practice of Medicine*, 1892, p. 700) also refers to the difference of the histological characters of the blood in acute (lymphatic) leucæmia. “The increase of the colorless elements is never so great as in the chronic form; a proportion of ten to one would be extreme. This increase takes place solely in the lymphocytes, other forms of leucocytes being present in diminished proportion. The haemoglobin shows a remarkable tendency to crystallize, so that in blood-slides which are kept for a short time Charcot’s octahedral crystals separate.”—Eds.]

**DIAGNOSTIC VALUE OF A SYSTOLIC MURMUR IN THE SECOND LEFT INTERCOSTAL SPACE.**—Professor Jaccoud (Paris), in discussing the diagnostic importance of a systolic souffle at the second left intercostal, calls attention to the prevalent error of regarding all such sounds as indicative of pulmonary stenosis of the pulmonary artery. In this space there are really two murmurs to be heard. If audible at the lower portion of the second intercostal space near the border of the sternum, the stethoscope resting on the sternal margin and in contact with the insertion of the third rib, the sound originates in the infundibulum of the artery, and indicates an infundibular or prearterial stenosis of the artery, of which the literature presents examples. It also may denote a congenital alteration of the heart itself, as persistence of the foramen Botalli, where, in the latter case, the murmur is heard with equal intensity all along the border of the sternum up to the second space.

The second site of auscultation is at the upper portion of the second left intercostal space, near the second intercostal cartilage. The stethoscope is placed two cms. out from the sternal border near the second rib. Here a souffle (systolic) is indicative of a stenosis of the pulmonary artery, yet it may exist without this whenever the left branch of the artery is affected, or its lumen defective, as in tuberculosis of the upper lobe of the left lung, from compression by tuberculous masses, or by adhesions which draw on the vessel. Both of these souffles in these two areas are equal in intensity, though they vary according to the degree of intensity of the lesion in grave cases, they being audible in the axilla, at the clavicle, anteriorly and posteriorly. As a rule, but slight modifications of the upper left lobe of the lung are required to give rise to a souffle, so that tuberculosis may thus be diagnosed early. All heart diseases must first be excluded, and finally, do not forget that one may have this souffle without any actual lesion from mere art. rio-sclerosis of the pulmonary artery.—*La Settimana Medica* No. 22, 189.—

[Dr. Barié has recently recorded a case of infundibular stenosis of the pulmonary artery in a woman with Addison's disease—*HABENEMANNIAN MONTHLY*, January, 1896—where the necropsy revealed a hard and whitish ring with an opening of five mms. situated about twenty-five mms. from the pulmonary artery orifice. Clinically, it produced an intense vibratory murmur (systolic), fremitus and a rasping murmur, which began with the systole and persisted till the second sound. It was best heard at the left chondro-sternal articulation and at the apex.—EDS.]

**AN AVAILABLE LOCAL ANTISEPTIC.**—In view of the large number of antisepsics which modern chemical research has placed at the disposal of the physician—a number which is constantly increasing—the study of this subject is beset with unusual difficulties. As Dr. R. C. Kenner (*New Albany Medical Herald*, April, 1896) justly says: “To one who surveys the field of therapeutic agents of this class with purely scientific disinterestedness, the evidence brought forward that any single one is the antiseptic sought for, will show that all are wanting in some special quality.” It is, therefore, necessary to specialize in the selection of an antiseptic; in other words, to choose each antiseptic with particular reference to its special field of utility. On the other hand, before a new remedy of this kind is accepted, it must be shown to possess advantages over the one it is intended to supersede. Thus, for instance, iodoform has enjoyed for many years a prominent place as a local antiseptic, and, in spite of its serious disadvantages, surgeons have been loth to discard it for one of the many substitutes that have been brought forward, until the superiority of the new-comer has been definitely proven. The time has now arrived when it may be confidently asserted that europhen, by reason of its efficiency and freedom from unpleasant or injurious effects, is entitled to occupy the place of iodoform in many conditions in which the latter has been formerly employed. Dr. Kenner testifies to the value of europhen in the following words: “As a local antiseptic it is particularly suited. It has been employed with most satisfaction in the treatment of ulcers, burns, skin affections, and venereal sores. This agent belongs to the iodine family, and is akin to iodoform, and applicable in cases in which that agent is usually employed. It is superior to this agent in several respects. It frequently acts as a cicatrizing. It forms a coating by its property of adhering closely to diseased surfaces which is of especial value. In this way the air is excluded, the surface protected, and healing favored. The use of europhen is not hindered by the very bad odor of iodoform, and then it is not poisonous as the latter frequently proves to be. In many respects it will prove superior to all other antisepsics which have as yet been offered to the profession, but we look upon it only as a local antiseptic having a specific field.”

## GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D., AND H. L. NORTHRUP, M.D.

**THE RAPID CURE OF GONORRHEA.**—Valentine (New York), writes concerning urethral irrigations of permanganate of potash as a means of aborting specific urethritis. He states that physicians must contend with the rather firmly-rooted superstition that the abortion of gonorrhœa is productive of stricture and other consequences. This may apply when attempts are made with escharotics, as silver nitrate; but their futility causes them soon to be discarded, to be evoked again when desperation at ill-success drives physicians and patients to any method which may be advanced.

Large irrigations with permanganate of potash, varied to meet the varying bacteriological indications, offer none of the discomforts, none of the sequelæ, which attend either too active treatment or neglect of treatment when it would prove most valuable. It is waiting that has caused authors to write down six weeks as the duration of an uncomplicated clap; but worse than this it allows infinite multiplication of the gonococci. It is this waiting that causes the majority of chronic urethritis, of strictures and other local disturbances, all equally fraught with danger to the patient's physical and mental welfare.

But we have a means of rendering the urinary mucous membrane a poor culture-medium for gonococci. This is in very copious irrigations by carefully graded hydrostatic pressure. The author uses potassic permanganate in acute cases and the same drug alone or with corrosive sublimate in chronic cases. Goldberg believes that potassic permanganate, when so employed, exerts direct gonococcidal action. There remains the mechanical view—that the large, heavy pressure of water alone suffices to produce the artificial œdema in which gonococci cannot live.

1. *Time for First Irrigation.*—When the microscope shows gonococci, irrigations should be begun at once. The strength of these irrigations, and whether they should be made only urethral or intra-vesical, must be governed by the conditions found.

2. *Strength, Frequency and Place of Irrigation.*—The strength of the solution should vary from 1 : 500 to 1 : 4000, and should be used once or twice daily.

3. *Concomitants of Gonorrhœa.*—It is self-evident that any condition, such as stricture, papillary hypertrophy, epithelial denudations, etc., existing from previous gonorrhœa, must be cured before a recovery from acute or chronic urethritis can be expected.

4. *Abatement of Pain.*—Pain on urinating is entirely arrested by the first irrigation, or so modified as to make it quite tolerable.

5. *Arrest of Flow.*—The discharge is at once stopped, or so diminished that bandages or other protections for the garments become entirely unnecessary.

6. *Drugs Internally.*—No hand injections or drugs by the mouth are given. The only exception hereto is a constipated patient, for whom cascara sagrada is prescribed.

7. *No Catheter* is used for urethral or intra-vesical irrigations, as it is sure to cover some part of the genito-urinary tract which may contain many foci of infection.

8. *Protecting Meatus.*—It is well to keep the meatus covered with absorbent cotton soaked in corrosive sublimate solution 1 : 6000.

9. *The Complications and Sequela of previous gonorrhœa* do not contra-indicate irrigations.

10. The complete apparatus employed for urethral and intra-vesical irrigations is made and sold for \$5.00 by F. Alfred Reichardt & Co., 27 Barclay Street, New York.

11. *Interval Between Irrigations.*—When two irrigations are made daily, twelve hours should intervene.—*International Journal of Surgery.*

**APPENDICITIS.**—White (Philadelphia) says that immediate operation is indicated whenever the onset of a case of appendicitis is marked by both suddenness and severity; whenever, during even a mild attack, the symptoms at the end of forty-eight hours are unrelieved or are growing worse; whenever, in cases seen later, a firm, slowly forming, well-defined mass is to be felt in the right iliac fossa; whenever at any time a sudden increase in the acuteness of the pain and a rapid diffusion of tenderness occur: whenever there is good reason for believing the appendix-infection to be tubercular in character; whenever attacks of any type have been numerous, or are increasing in either number or gravity, or have unfitted the patient for work or activity, or have caused local symptoms which are permanent and persistent, or have at any time put the patient's life in great danger.—*International Journal of Surgery.*

**THE ABDOMINAL BELT AFTER COELIOTOMIES.**—As the result of correspondence with a large number of surgeons, McGuire (Richmond) states that the majority of the writers employ an abdominal belt after coeliotomies—some from conviction, some from doubt, and some from indifference. The fact, however, that a single competent observer has discarded its use and found no reason to regret abandoning artificial support, proves that in the large majority of cases it is unnecessary. Because an abdominal belt is indicated in some instances, is no reason why it should be employed in all cases. Routine practice is bad practice.—*Maryland Medical Journal.*

**CAPILLARY ABDOMINAL DRAINAGE.**—According to Van Hook the following propositions are warranted:

1. Since the quantity of fluid to be removed per hour cannot be more than ap-

proximately estimated, the amount of drainage material employed must be well equal to maximum requirements.

2. Capillary (gauze) drainage has the advantage over tubular drainage that a minimum amount of damage is inflicted upon the peritoneum.

3. Capillary drainage acts independently of gravity and suction apparatus, and delivers a constant current of fluid.

4. By its appropriate disposition among the peritoneal-clad viscera it not only aids coagulation in ruptured capillaries, but carries away fluids secreted at some distance (10 centimetres) from the limits of the gauze, since capillary action takes place between the closely approximated peritoneal surfaces.

5. The amount of plastic reaction depends more upon the infection present than upon the action of the gauze.

6. The utmost attention should be paid in septic cases to the accurate application of gauze over the uninfected surfaces of the peritoneum near the focus of infection, this gauze should not be disturbed or replaced during or at the end of the operation.—*American Gynaecological Journal*.

## GYNAECOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D.

**TRANSACTIONS OF THE GYNAECOLOGICAL CONGRESS AT GENEVA, SEPTEMBER, 1896. DISCUSSION ON THE TREATMENT OF PELVIC SUPPURATION.**—Henrotin (Chicago).—Ninety per cent. of all cases of pelvic suppuration can be cured without extirpation of the organs. The vaginal incision must be performed as early as possible, in any case as soon as pus is found in the abdomen, then drainage of the abscess cavity and curettement of the uterus. Even chronic cases can be treated in a similar manner. He recommends extirpation by laparotomy for unilateral salpingitis and pyosalpynx; double vaginal castration for bilateral salpingitis and adhesions, and reserves hystero-salpingo-ovariectomy for multiple and extensive pelvic suppuration.

Richelot (Paris), Each of the three methods, castration by laparotomy, vaginal incision or vaginal hysterectomy has its advantages.

Vaginal incision is recommended for recent thin-walled collections of pus originating in the puerperium.

Laparotomy is suited to young women with unilateral disease of the appendages, as only by this method can the diseased tube be removed and the sound ovary preserved.

Unfavorable for successful laparotomy are virulent pus tubes, extensive adhesions with the small intestines which are easily injured, and a uterus left in the abdomen after an operation.

Hystero-salpingo-ovariectomy has a relatively favorable prognosis of 4.5 per cent.

Hartmann (Paris), Conservative methods should be employed in all cases. He has obtained many recoveries by medical treatment, also by dilatation of the uterus and curettage.

Pean (Paris), Has a mortality of 3.00 per cent. in about three hundred cases of vaginal hysterectomy. If only the adnexa are removed in suppurative cases it not infrequently happens that the uterus must be removed later for the persistent suppuration.

Leopold (Dresden), He removes small unilateral and sometimes bilateral disease of the appendages by laparotomy, mortality 1 per cent. He reserves vaginal hysterectomy for inflammations of the uterus and appendages which have lasted for years and the organs are firmly bound down by adhesions. He has performed vaginal hysterectomy in fifty-seven such severe cases of pelvic suppuration with one death. He always uses the ligature and never has had an injury of an adjoining organ. If the vagina is narrow he finds short incisions for dilatation very advantageous. He then carefully separates the uterus from the rectum and ties the uterine artery on each side of the cervix; after this there is very little bleeding in the field of operation. Pointing pus sacks are opened, emptied, and closed with clamps, which makes it more easy to extirpate the pus sacs. The

entire tumor is finally pedunculated and removed. Pains must be taken to place the superior ligature high up.

Jacobs (Brussels). Extra-peritoneal suppuration requires of the pus sacs by cæliotomy either anterior lateral or posterior, with the thermo-cautery to avoid wound infection. All cases of intra-peritoneal pelvic suppuration should be attacked by the vagina. Laparotomy should be reserved for the exceptional cases and should never be compared with vaginal hysterectomy. He removes the forceps immediately after the operation and treats the stumps with ligatures. If there is no pus in the abdomen the vagina is closed at once, but if there has been pus vaginal drainage is employed.—*Centralblatt für Gynäkologie*, September 19, 1896.

**THE TREATMENT OF ECLAMPSIA.**—Charpentier (Paris).—The urine of every pregnant woman should be examined with the greatest care for albumin. Every woman whose urine contains albumin is liable to an attack of eclampsia. If there is only a trace of albumin an absolute strict and exclusive milk diet must be used as a preventive treatment "par excellence." In all cases in which there is œdema the milk diet is indicated, though it is not absolutely necessary to insist on it.

In a case of eclampsia with cyanosis in a healthy woman venesection should be employed to the extent of 300 to 500 g. in the beginning and followed by the use of hydrate of chloral.

The eclamptic attacks are controlled by the use of chloroform inhalations while at the same time diuresis is favored by subcutaneous transfusion of a physiological salt solution.

If the patient is weak and cyanosis is not pronounced, and the convulsions are not frequent, the treatment with chloral may be sufficient. One should wait for spontaneous pains and the unaided termination of labor so long as the case continues to progress without incident.

If pains are present and labor is not terminated, in consequence of too weak contractions or too long intervals between pains, the forceps must be applied or version be performed with extraction, if the child is living; if the child is dead then craniotomy is indicated. Complete dilatation or dilatability of the cervix is necessary for the safe delivery of the mother, i.e., without injury of the soft parts.

The induction of premature labor should be reserved for exceptional cases.

Cæsarian section and also accoucheur force should be considered in the treatment of eclampsia only as a last resort, and justified only when the mother's life is in danger and after all medication has failed.

Veit (Leyden). It is not yet proven that the prognosis has been improved materially by forced delivery in deep narcosis (dilatation of the parturient canal by rubber bags or by incisions or Cæsarian section).

The recent reports on the success of venesection are not numerous enough to warrant an opinion.

The results obtained from the systematic use of large doses of morphine appear to surpass those from other measures.

There is no rational treatment of eclampsia as long as the pathology of eclampsia is not explained. It is probable that the disease may originate in various ways.

The best results are obtained by hastening labor in some safe way, as rupturing the membranes, delivery after complete dilatation of the soft parts, the use of large doses of morphine to suppress the attacks; avoiding the administration of any substances by the mouth in insensible patients and exciting diaphoresis by external measures. Tarnier (Paris).—An absolute milk diet is positively necessary in the prophylactic treatment of eclampsia. Experiments with a mixed diet have given bad results. The milk diet is not only indicated for women suffering with albuminuria but also for those who during pregnancy complain of nervous disturbances, as headache, sleeplessness, etc.

The maternal mortality in his clinic from 1833 to 187 (observations of his predecessor) was 37 per cent.

From 1889 to 1891 he treated eclampsia with chloroform, chloral and venesection with equally bad results. Maternal mortality 33 per cent.

From 1892 to 1895 he treated eclampsia by venesection, strong cathartics, chloroform and chloral and especially with the milk diet introduced, if necessary, with the stomach tube. The maternal mortality, including the patients in the out-patient department, has been reduced to 9 per cent. and from Jan. 1 to Sept. 1, there has been no death from eclampsia.—*Ibid.*

## MONTHLY RETROSPECT

### OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D.,  
FRANK H. PRITCHARD, M.D., AND F. MORTIMER LAWRENCE, M.D.

**THE THERAPEUTICS OF HEREDITARY SYPHILIS.**—According to Dr. J. P. Cobb, the medicinal treatment of hereditary syphilis is as varied as the manifestations of the disease. He is not one of those who find in mercurius the sole or even the most frequently indicated remedy. Mercurius does not cover all the symptoms of secondary syphilis, and almost none of those of the tertiary stage; hereditary syphilis presents conditions and symptoms corresponding to the second and third stages of the acquired disease. Mucous ulcerations, characterized by extensive inflammation and swelling, will demand mercurius; also some forms of dyspeptic disorders and bone lesions with nightly aggravations.

The catarrhal inflammations are more apt to demand some of the various kali preparations. Hereditary syphilitic symptoms, like the kali pathogeneses, are characterized by a low grade of fever. Kreosotum will often control the foul-smelling diarrhoeas and rob the child of its usual penetrating odor. It is also of service in controlling dental caries, and in healing the cracks and fissures at the commissure of the mouth.

The iodide of potash is a valuable remedy with which to arrest the progress of lesions of the glandular, the nervous, and the osseous systems, but it can frequently be well followed or replaced by the iodide of calcarea, or the iodide of arsenicum, in lesion of the glands; by silicea or zincum, or sulphur, in those of the nervous system; and by hepar sulphur, aluin, or nitric acid in those of the osseous system.

Mezereum, thuja, or sulphur are remedies frequently required to clear up the various skin manifestations.

Strictly homœopathic medication will yield the best results in the treatment of hereditary syphilis, and we do not need very often to resort to so-called antidotal treatment.—*The Hom. Jour. of Obs., Gyn. and Ped.*, July, 1893.

**THE ARSENICAL FEVERS.**—Analyzing the action of *arsenic* upon the nervous centres, Dr. Edward Fornias notes that the pyrogenic agents, which, absorbed into the blood, act on the thermic centres, giving rise to the fevers indicative of this drug, are known to be derived from the marsh miasm (protozoon), from other occult sources (bacteria), and from local inflammatory foci (toxin, etc.). In other words, the *arsenic* fevers are either *specific*, due to the introduction of a specific poison into the system, or *symptomatic*, dependent on acute local inflammation, or occur in connection with persistent purulent discharge, as that met with in phthisis; and in their evolution they exhibit a continued, remittent, or intermittent course, periodicity being the most striking feature. More or less, they are all attended by great restlessness and anxiety (aconite), insatiable thirst, hyperthermia, sudden sinking of the forces, prostration and progressive emaciation. The chief representatives of the above classifications are: (1.) The *malaria* *intermittent type*, characterized by violent, long-lasting, principally incom-

plete paroxysms, the one or the other stage being absent or feebly present; and by intermissions which rarely if ever are entirely clear. (2.) The *atazo dynamic type of low, continued fever*, principally typhoid, characterized by a mixture of erythema and depression. (3.) The *inflammatory type*, attending active inflammation of the various organs and tissues of the body (stomach, bowels, liver, spleen, glands, etc.), characterized by malignity, decomposition, and even destruction of the parts involved. (4.) The *hectic type*, intermittent or remittent, usually associated with chronic suppuration and wasting disease, and characterized by abolition of nutrition, colligative discharges, and progressive loss of force and flesh.

—*Hah. Advocate*, July 15, 1896.

**THE UTERINE ACTION OF VIBURNUM OPULUS.**—Dr. Cowperthwaite says that the provings of *viburnum* prove conclusively its action upon the uterus. All women provers reported symptoms simulating uterine congestion, and had disturbed and painful menstruation. Clinically the drug has proved invaluable in congestive and neuralgic dysmenorrhœa, and has often given relief in the membranous and obstructive varieties. *Viburnum* rarely fails to give prompt results if its symptoms are present, but unfortunately its action seems to be more palliative than curative, as the conditions usually return after three months. Dr. Cowperthwaite is inclined to think that if the higher potencies were used this would not be the case.—*Medical Era*, August, 1893.

**THE ACTION OF PLATINUM ON THE UTERUS.**—*Platinum* affects the uterus only through its depressing effect upon the nerve centres, but such results are so uniform and characteristic, almost invariable, that they become the chief feature of the drug's action. While its use is largely confined to those cases where uterine and ovarian irritation have given rise to the characteristic and well-known mental states of *platinum* as present in melancholia, hysteria, nymphomania, pruritis, vaginismus, etc., yet the fact should not be overlooked that platinum is a most valuable remedy in induration of the uterus, fibroid tumors, and prolapsus, as a rule the platinum patient has not only the characteristic mental symptoms, but also a menorrhœgia of dark, clotted blood, and an abnormal sexual appetite, while probably the most important and ever present characteristic is a painful sensitiveness of the parts.—A. C. Cowperthwaite, M.D., in *Medical Era*, August, 1896.

**THE UTERINE SPHERE OF PULSATILLA.**—According to Dr. A. C. Cowperthwaite, *pulsatilla* clinically stands at the head of our uterine remedies, but its patho-genetic effects upon the uterus are not so decidedly pronounced as they are in several other drugs. Not only do we find the general catarrhal effects of *pulsatilla* manifest upon the endometrium, but also many other evidences of deranged function arising in all probability through the influence of the drug upon the cerebro-spinal system. There is no evidence that *pulsatilla* produces any tissue changes, but its functional disturbances are quite numerous, and with which all are so familiar that they need not be detailed. The acrid, milky leucorrhœa, and the well known irregularities of menstruation are the most important. A heavy, pressive pain in the small of the back is the most constant symptom. The *pulsatilla* temperament and the gastric derangements so characteristic of the drug must not be overlooked. So too should we remember the usefulness of *pulsatilla* in disorders of pregnancy and after parturition. It is said, among other things, to correct malpositions of the fetus, by altering abnormal conditions of the uterus. Physicians have been warned not to prescribe *pulsatilla* during pregnancy, on account of the possible danger of producing abnormal conditions and thus causing a malposition. He has never been able to verify these statements and is inclined to believe that they only emanated from an impractical brain, and were due to a belief in power of highly potentized drugs beyond that which reason and common sense dictate.—*Medical Era*, August, 1893.

**PETROSELINUM IN URINARY INCONTINENCE.**—Dr. Bukk G. Carleton records the case of a female, wt. 2 years 6 months, in whom there was urinary incontinence of six months' duration. No abnormal condition noticed in first two years. Treatment by Old- and New-School physicians, with usual hygiene for the six months, availed nothing and the case gradually grew worse. There were no deformities of the parts. Chemical and microscopical examination of the urine

gave evidence of no abnormal condition. *Pathogenetic symptom*: frequent desire to urinate. *Clinical symptoms*: sudden irresistible desire to urinate. The child awakens at night, saying "want to river," and, if not taken up at once, the urine is passed involuntarily. During the day the desire is frequent and sudden, the discharge of urine occurring before the child could call the mother or nurse. *Petroelinum 3x*, the indicated remedy, cured in one week.—*N. A. Journal of Hom.*, October, 1896.

**CAUSTICUM IN VERRUCA.**—Dr. E. M. Baruch reports the case of an unmarried seamstress, *et. 28*, who for a year had been afflicted with verruca affecting both hands, dorsal and palmar surfaces. The pathogenetic symptoms included menses too early and profuse, with a little passed from time to time after cessation; violent pain in abdomen; mind taciturn and distant; melancholy. There were large, jagged, pedunculated warts, bleeding easily. *Causticum 30x* cured in about nineteen days.—*N. A. Journal of Hom.*, October, 1896.

**THUJA IN VERRUCA.**—In a second case reported by Dr. Baruch, the patient, *et. 21* and single, suffered from gonorrhœa. Clinically he found figwarts at vulva, moist, cauliflower like. *Thuja 3x* cured in about ten days.—*N. A. Journal of Hom.*, October, 1896.

**PALLIUM IN OVARITIS.**—Dr W. G. Fralick records the case of a married woman, *et. 34*, who had been many years ill. As a pathogenetic symptom, he notes headache in places. Clinically, there was inclination to weep, sallow complexion, blue half-circles under the eyes; swelling and induration of right side of abdomen; right ovary swollen and sensitive; drawing in right ovary downward and forward; bearing down; yellowish leucorrhœa; ovaries tender on pressure; right enlarged, also right tube; uterus retroflexed and prolapsed, when thigh is flexed when lying down on left side. Receiving *palladium 3x*, the patient reported improvement on third day, and was nearly well in three months.—*N. A. Journal of Hom.*, October, 1896.

**AN INVOLUNTARY PROVING OF GELSEMIUM.**—Dr. S. B. Moon reports that, on June 29th, a sandy-complexioned, well-formed man aged 43 years, a painter by trade, weighing 125 pounds, and measuring 4 feet 5 inches, sent a messenger to his office for medicine. The patient complained of severe pains above the left eye, with nausea and gnawing in the stomach, followed by a burning sensation in stomach, which would entirely disappear then soon return. The patient had been treated for three attacks of left supra-orbital neuralgia within the last two years.

R. *Gelsemium semp.* (green tincture), five minimis, and *nux vomica* (second dilution), five minimis, alternately every half hour.

On July 1st the following symptoms were present:

*Mind*.—Memory poor.

*Head*.—Feels as if suspended or floating in air. Staggers.

*Eyes*.—Seen double. Near objects seem to be far away.

*Ears*.—Deafness in left ear.

*Stomach*.—Nausea, gnawing and heat better.

*Tongue*.—Coated yellow.

*Stool*.—Natural.

*Sleep*.—Languid and drowsy, but cannot sleep.

*Fever*.—Hot and feverish; at times chilly.

*Pulse*.—Normal.

R. A cup of strong coffee every three hours.

On July 3d all symptoms have disappeared excepting those of the eye, which are still prominent.

R. *Arsenicum*, every two hours.

On July 6th physical and mental conditions of the patient normal.—*Medical Century*, October 1, 1895.

**PHYTOLACCA IN MASTITIS.**—Dr. Mackenzie records the case of a housewife, *et. 32*, whose first infant was 8 months old. The milk ceased in a month, and since then the right mamma had developed an indurated lobe in the upper part,

which was painful and tender. Both nipples were excoriated and surrounded by a papular eruption; her bowels were costive. Ordered *bryonia* 1x.

Next week the right breast was less swollen, but the induration was greater, and the eruption on both mammae had increased. *Phytolacra* 1x. The following week the swelling and induration were hardly perceptible, the eruption was much better, but both nipples were very irritable and itched intensely. Repeated *phytolacca*. There was further marked improvement on the next visit, there being only some erythematous rash remaining around nipples, and a patch on the waist had appeared. For this *sulphur* 3x was given, and speedily removed the last trace of her trouble.—*Monthly Hom. Review*, July 1, 1893.

**A CASE OF ROUND-CELLED SARCOMA OF THE SOFT PALATE CURED BY ARSENIC.**—Dr. R. Bolde records a case of round-celled sarcoma of the soft palate which, ulcerating, had spread with great rapidity to the pillars of the fauces, the tonsils and the right portion of the upper jaw, giving rise to swelling of the lymph-glands as well as disturbances of deglutition and respiration. This rapid diffusion of the tumor, at first regarded as a gumma on account of the rapid softening, led to its being treated specifically. The rapid decline of the general health forced a diagnosis of a malignant neoplasm, which was confirmed by microscopic examination to be a round-celled sarcoma. Surgical measures being out of the question, an arsenical "course" was tried. A solution of arsenite of soda, 1 : 10<sup>v</sup>, was injected hypodermatically into the interscapular region, beginning with a daily dose of 4 mgms. and gradually increasing it to 2 cgms. The injections were well tolerated, but at first were without effect, for a new metastasis appeared above the right upper canine tooth. After eleven injections an amelioration was apparent, for the ulcerated surfaces became cleaner, their margins began to cicatrize and the metastases disappeared. The general state of the patient also improved visibly. The final result was that after eighty-four injections of the arsenical preparation in the space of eight weeks, the patient gained 9½ kgms. in weight, so that he could be discharged with the growth nearly cicatrized; provisionally cured.—*La Settimana Medica*, No. 22, 1896. [In the HAHNEMANNIAN MONTHLY, p. 131, 1893, is an abstract of an article where a case of a giant-cell sarcoma of the tibia is reported cured by the use of arsenic internally. Arsenic is the chief ingredient of all remedies for the cure of cancer by external application. Plunket's caustic, the Paris arsenical paste, the paste of Frère Come, Febure's remedy, etc., all contain arsenic. Cancer is one of the diseases in which arsenical preparations have been specially recommended . . . internally it has been administered by Loder, Lentini . . . Hahnemann, etc. The famous powder of Pierre Alliot, which made such a *bruit* in the middle of the seventeenth century, was a preparation of arsenic.—*Dictionnaire de Médecine et de Chirurgie Pratiques*, vol. iii., p. 376, 1829. In 1778 Ronnow published in the *Mémoires* of the Academy of Science of Stockholm a dissertation, in which he announced that during the fifty years in which he had made use of arsenic as a remedy in cancers, he had cured thirty undoubted cases.—Eds.]

**AN ANALGESIC MIXTURE FOR THE PAINLESS EXTRACTION OF TEETH.**—Dr. D. Frohmann recommends the following formula for the painless extraction of teeth. I insert it for the use of our country *confrères* who are often called upon to do this work: Muriate cocaine, 0.10 0.20; muriate morphine, 0.025; muriate sodium, 0.20; antipyrin, 1.0-2.0, guaiacol, gtts. ij, distilled water, 100.<sup>v</sup>. Several punctures are made into the gums about the tooth, and a few drops injected in each until the gum appears bloodless. The tooth may then be extracted without pain. The morphine and antipyrine are added in order to prevent the late appearance of the pains after the cocaine has ceased to act.—*La Semaine Médicale*, No. 26, 1896.

# THE HAHNEMANNIAN MONTHLY.

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DECEMBER, 1896.

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## ARE THE EVIDENCES OF HOMEOPATHY INSUFFICIENT?

BY R. E. DUDGEON, M.D., LONDON, ENGLAND.

My esteemed friend, Dr. Conrad Wesselhoeft, in the interesting lecture published in the August number of the HAHNEMANNIAN MONTHLY, thinks that Hahnemann was not justified in deducing the therapeutic rule with which his name is associated, from the evidence before him. He says that Hahnemann's experiment with cinchona bark, related in a note to his translation of Cullen's *Materia Medica*, in 1790, is the only experiment he ever made in order to establish his principle of cure, and that he considered the proof of the law furnished by this experiment sufficient. I think Dr. Wesselhoeft is mistaken, and I believe that a brief account, taken from his published writings, of the work of Hahnemann in connection with the discovery and development of the law of similars, will show that he only came to the conclusion that it was the true guiding principle for the selection of the remedy after long and laborious research and experiment.

In Hahnemann's letter to Hufeland he says: "I had conscientious scruples about treating unknown morbid states in my suffering fellow-creatures with these unknown medicines, which, being powerful substances, might, if they were not exactly suit-

able, easily change life into death." So, after his marriage, he gave up practice and devoted himself to chemistry and literature, earning a precarious livelihood by translating books. It was while translating Cullen's *Materia Medica* (in 1790) that, being dissatisfied with the author's explanation of the cure of ague by cinchona bark, the idea occurred to him to try the effects of this medicine on himself, he being at the time in perfect health, in order to see if he could thus obtain a more satisfactory reason for its curative action in ague than that offered by Cullen. He found that a considerable dose of the powder evoked a series of symptoms closely resembling a paroxysm of marsh-fever which he had experienced in Transylvania. It is asserted by some of his opponents that the symptoms Hahnemann observed from the medicine were not those of ague at all; but Hahnemann does not say they resembled an attack of ague in general, but that they were exactly like the form of the disease from which he himself had suffered, and we may be sure he would not have said so had it not been the case. Others assert, that he had still the Transylvania fever in his system, but in a dormant state, and that the large dose of bark merely roused the latent fever into activity. Against this it should be borne in mind, that he did not experience a real ague of any known kind by his dose of bark; for the essence of ague is its intermittent character, and every trial of the medicine, and he made several, was only followed by one attack of fever and no more. Moreover, upwards of ten years had elapsed since his departure from Transylvania, and we may credit him with being free from all malarious infection when he tried the bark upon himself in 1790; he was "in perfect health," as he says in the letter to Hufeland. There is now no room for doubting that cinchona and its alkaloid, quinine, can produce febrile attacks of an intermittent character. Proof of this will be found in the 14th and 15th vols. of the *British Journal of Homœopathy*, and elsewhere.

In his letter to Hufeland, Hahnemann gives a somewhat different version of his trial of china to what we read in the note to Cullen. After arriving by an exhaustive course of ratiocination to the conclusion that medicines could only cure diseases similar to those they can produce on the healthy, he adds: "If I am not completely deceived, such is really the case; other-

wise, how was it that that violent tertian and that other quotidian fever, which I cured without after sufferings, four and six weeks ago, by means of a few drops of china tincture, not knowing how the cure was effected, presented almost precisely the array of symptoms which I observed on myself yesterday and to-day after gradually taking, by way of experiment, while in good health, four drachms of good cinchona bark?" The two versions he gives are not inconsistent with, but are corroborative of, one another.

But, to return to our subject, Hahnemann, finding that his dose of bark brought on a febrile attack resembling a paroxysm of the ague he had himself suffered from, seems to have thought that this might afford a clue to the principle governing the relation of medicines to disease. He was, of course, familiar with the two chief rules for the selection of the remedy, which had been proposed, discussed, and acted on by physicians ever since the days of Hippocrates, *contraria contrariis* and *similia similibus*. The first was by far the most popular, the last had only been occasionally put forward as a good therapeutic rule in some cases. Hahnemann's cinchona experiment seemed to point rather to the unpopular *similia similibus* than to its potent rival, *contraria contrariis*. But he did not rush at once into the arena of medical strife, crying, "Eureka! I have found the true principle for the selection of the remedy." He acted differently. He tells us what he did in his letter to Hufeland: "I now commenced to make a collection of the disagreeable symptoms experienced and casually mentioned in their books by observers, here and there, from medicines introduced in considerable quantity into the stomachs of healthy individuals. But as these were not numerous, I set myself diligently to work to test several medicines on the healthy body, and behold! the carefully observed symptoms they produced [recorded in the *Fragmenta*] corresponded wonderfully with the symptoms of the morbid states they could cure easily and without relapse."

Six years after commencing these researches among ancient medical records and provings of medicines on the healthy, he published his essay *On a New Principle* in *Hufeland's Journal*.

He did not then claim for homœopathy that it was the general, still less that it was the sole, rule for the selection of the remedy. He states his case in the following words: "We

should imitate nature, which sometimes cures a chronic disease by superadding another, and employ in the (especially chronic) disease we wish to cure, that medicine which is able to cause another very similar artificial disease, and the former will be cured ; *similia similibus.*"

He gives a number of instances of unconscious homœopathic cures by physicians of the old school in this way, but he does not mention the works from which they are taken. Several cases are from his own practice, but though he does not seem as yet to have set about a methodical proving of drugs, he has evidently ascertained some characteristic effects of a few powerful medicines in a desultory way.

After this he seems to have devoted himself more diligently to the proving of medicines, for in 1805 he published the results of his trials on himself of twenty-six medicines, together with the observations of medical authors on the effects of these medicines on more or less healthy subjects. This book is in Latin ; its full title is : *Fragmenta de viribus medicamentorum positivis, sive in sano corpore humano observatis.* It is remarkable that in this work, though he wrote a long preface to it, he makes no allusion to the therapeutic rule *similia similibus.* But the trials he had made of drugs on himself, and his own extensive investigations among the records of medical writers, had apparently sufficed to convince him that the therapeutic rule of similars was applicable to the treatment of all diseases, acute and chronic. Accordingly, in the *Medicine of Experience*, published the same or the following year, he boldly claims for the law of similars the exclusive right to be considered the true rule for the selection of the remedy. His words are : " In order to be able to cure, we shall only require to offer to the existing abnormal irritation of the disease a suitable medicine ; that is to say, another morbid force whose effect is very similar to that the disease displays." It is noteworthy that Hahnemann throughout this essay nowhere makes use of the formula *similia similibus*, though he had employed it in his earlier essay *On a New Principle*. Nor does he allude to the unconscious homœopathic cures recorded by previous writers, which constituted a not inconsiderable feature of his first essay. The only allusion he makes to his provings is a casual reference to the *Fragmenta* in a note.

The next five years must have been very busy ones. The *Organon* appeared in 1810, and it contains in the Introduction a large number of cases of the unconscious homœopathic employment of drugs by physicians of the traditional school.\* Hahnemann must likewise have labored hard in the proving of medicines, for in 1811 he published the first volume of the *Materia Medica Pura*, containing the pathogeneses of twelve medicines, all obtained by provings on himself (and probably on members of his family, though not so stated), for as yet he had no enthusiastic disciples to help him.

He had now no doubt about the truth of the therapeutic rule he had enunciated modestly and, as it were, tentatively, fifteen years before. I think no one who considers carefully the whole history of Hahnemann's cautious and deliberate action in his grand reform of the healing art will agree with Dr. Wesselhoeft in believing that "Hahnemann considered the proof of the law furnished by his personal test of Peruvian bark as sufficient."

To me it appears that Hahnemann was not at all satisfied of the sufficiency of this proof, and, as he tells us, he set himself diligently to test some medicines on the healthy, in order to ascertain if the artificial morbid symptoms they occasioned resembled the symptoms of the diseases they were known to cure. And even after six years of such controlling experiments he did not think he was entitled to assert that the treatment by similarly acting medicines was suitable for all diseases, but only for some, chiefly chronic ones. Five years after his experiment with cinchona bark we find him treating a case of *crusta lactea* in a most unhomœopathic way, by the external application of a solution of *hepar sulphuris* (v. *B. J. of H.* xlii., p. 209). It is curious to remark here that he attributes the disease to a minute living organism, which he thinks is killed by the sulphuretted hydrogen disengaged from the *hepar*. This is not the only occasion on which Hahnemann anticipated the modern doctrine of the microbic origin of disease, for he believed that cholera also was caused by minute invisible organisms, which he sought to kill by his strong doses of camphor internally, by mouth and rectum, and externally by fumigation and rubbing-in on the skin (*Lesser Writings*, p. 866). Three years after the publica-

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\* These instances of unconscious homœopathy are repeated in every edition of the *Organon* except the last.

tion of his essay *On a New Principle*, viz., in 1799, the last part of his great work, the *Apothekerlexicon*, was published. This book shows no trace of the application of the law of similars in the therapeutic uses of the drugs treated of. In 1800 we find him translating a book of old-school prescriptions. Perhaps, like Romeo's apothecary, it was his poverty, not his will, that made him consent to do what must have been so distasteful to him. However, he had his revenge for the violence he thus did to his therapeutic convictions, for he wrote a sort of counterblast to the work in the shape of a preface and numerous notes pointing out the absurdity and irrationality of many of the composite prescriptions in the book (see *Lesser Writings*, p. 398).

I think I have made it clear that Hahnemann was not all at once convinced that the therapeutic rule, expressed in the formula *similia similibus curentur*, was the only true guide to the selection of the remedy, by his one solitary experiment with cinchona bark. With just as much plausibility might we assert that to Newton all at once was revealed the great law of nature that "every body or portion of matter attracts and is attracted directly as its quantity of matter, and inversely as the square of its distance from the attracting body," by the fall of the historical apple. The bark in the one case and the apple in the other set these great men thinking whether there was not some general law of nature at the back of the phenomenon they observed, and it was, in both cases, only slowly and by multiplied experiments and profound reflection that gravitation was revealed to the one, homœopathy to the other. Since Newton's time hundreds of observers have recorded thousands of phenomena which prove the correctness of Newton's formula. And the truth of Hahnemann's assertion that the true general therapeutic rule is expressed by the formula, *similia similibus curentur*, has been demonstrated by a similar cloud of witnesses. So that I do not share Dr. Wesselhoeft's regret that the fundamental principle of homœopathy has not been sufficiently proved. On the contrary, I am fully persuaded that it was proved, as far as medical facts are capable of proof, by Hahnemann himself as early as 1805, the date of his *Medicine of Experience*, and shown to be extremely probable nine years previously in his ever-memorable essay *On a New Principle*, the centenary of which we celebrate this year.

Believing, as I do, that *similia similibus* has been placed on a foundation of inexpugnable truth by Hahnemann, and that the experience and observations of his thousands of disciples have constantly tended to fortify this position, I am not concerned to join Dr. Wesselhoeft in searching for fresh evidence of the truth of homœopathy. Nor do I consider the means he proposes the best adapted to effect his object.

In the early days of homœopathy statistics of the comparative mortality in allopathic and homœopathic hospitals were used with considerable effect in convincing the public of the superiority of Hahnemann's system. But on the profession generally they had little effect. Medical men know too well the difficulty of making such comparisons, and even where the conditions in the hospitals compared seem to be tolerably alike, the opponents of homœopathy always tried to vitiate the comparison by alleging that the partisans of the more successful method were ignoramuses who were unable to diagnose the diseases, or that they fraudulently represented slight as serious diseases. This was the line taken by Dr. Routh in his famous *Fallacies of Homeopathy*; and whilst his tables of comparative statistics in hospitals tell vastly in favor of homœopathy, he whittles away the trustworthiness of the homœopathic physicians in the manner just stated.

Dr. Wesselhoeft's proposal that our hospitals should receive and observe, without giving any medicine whatever, for several years, "all, or a certain class of acute cases, say pneumonia or typhoids," for the purpose of comparing the results with similar cases medically treated, is impracticable; for I believe it would be impossible to find a homœopathic physician who is not thoroughly convinced that homœopathic treatment, especially in pneumonia, has a decidedly favorable influence, and he could not contemplate calmly his patients dying of that disease without an effort on his part to save them by approved homœopathic medication. In Dr. Routh's book, just alluded to, the mortality from pneumonia in the homœopathic hospitals is only 5.7 per cent., whereas in allopathic hospitals it is 24 per cent. Even if we take Dietl's wonderfully small mortality of 7.5 per cent. under expectant or non-medicinal treatment, the superiority of homœopathy is, as Professor Henderson has shown, demonstrated in another way, to wit, by the much

shorter duration of the cases treated homœopathically, viz., 11.66 days under homœopathy, 28 days under allopathy. In connection with this disease, there is a passage in Dr. Wesselhoeft's article which I confess I am unable to understand. He says: "What would we think of a man stating that he had, in 30 years of practice, lost only 5 cases of pneumonia? The inference would be that he saved 100 per cent. of his cases." The percentage would depend entirely on how many cases he had treated during these 30 years. As stated, his *mortality* might be anything from 1 to 100 per cent., but if he lost 5 cases he could not possibly have *saved* 100 per cent. however many cases he might have treated.

Dr. Wesselhoeft advocates the old, bad way of experimenting on animals with drugs. Surely this has been done to satiety in the old school. And with what useful results? Look at the ponderous tomes of Lauder Brunton, Schroff, Binz and other champions of pharmacology. Can we obtain a poor ha'porth of useful information with regard to the true action of drugs on human beings from all that intolerable quantity of experiments on dogs, cats, rabbits, guinea pigs and frogs? I doubt if the "omnivorous pig," the mollusks, insects and fishes recommended by Dr. Wesselhoeft for such "provings" would furnish any better results.

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#### THE INDUCTION OF ABORTION, MISCARRIAGE AND PREMATURE LABOR, WITH REPORT OF CASES.

BY L. L. DANFORTH, M.D., NEW YORK CITY.

(Read before the New York State Homœopathic Medical Society, Rochester, Sept. 22, 1896.)

THE induction of abortion is an operation which no honorable man will undertake without good reason for so doing. While distinctly sacrificial, so far as the foetus is concerned, it offers to the mother a means of escape from perils which the continuation of pregnancy would render inevitable. Under normal conditions a crime, it becomes in some cases a procedure of necessity, and, paradoxical as it may seem, it is as conservative as it is destructive and radical. The lesser of two

evils is chosen, the unimportant life is sacrificed for the more important.

Fortunately, the necessity for premature emptying of the uterus does not often occur, but when the necessity does arise, it behooves the physician to realize the danger ere it is too late. Perhaps the operation is sometimes done unnecessarily, but the converse is also true; the operation is not done when it is demanded, or not done quickly enough, and thus two lives are sacrificed when one, and the more valued, might have been saved.

The natural dread which physicians have of interfering with nature's processes, and the fear they have that some untoward result may occur from their action, sometimes leads them to defer too long the active measures which, under other circumstances, they would not fail to adopt. This hesitancy is no doubt due, in part, to the reliance which we are all inclined to place upon the natural recuperative powers of the organism when a physiological function is involved. A careful scrutiny of all the symptoms present should lead one—aided as should always be the case, by wise counsel—to arrive at a correct solution of the problem.

I shall divide the subject into three parts, corresponding to the three periods of pregnancy.

*Induced abortion* is the premature emptying of the uterus during the first three months of pregnancy.

*Induced miscarriage*, the premature emptying of the uterus at any time from the third month to the time of viability of the child (the 7th month); and

*The induction of premature labor*, the emptying of the uterus from the 7th month up to the full term.

In the first period the operation may be indicated when maternal life is endangered by grave pathological conditions of the foetus or mother. The former are comparatively infrequent.

Cystic disease of the chorion, catarrhal disease of the decidua, and the acute form of hydramnios, are the chief causes of foetal death, and when present may develop such symptoms as to call for the thorough emptying of the uterus.

Certain serious pathological conditions on the part of the mother are more often observed, and may render the operation imperative. In the early months we meet with pernicious or

uncontrollable vomiting, pernicious anæmia, pronounced melancholia with suicidal tendencies, chorea and epilepsy.

There are, also, certain irremediable conditions of the genitals which may call for early emptying of the uterus, such as irreducible displacements, the pregnancy supervening in an old case of retroversion or retroflexion with firm adhesions; large tumors in the uterus or pelvic cavity; cancer of the cervix uteri.

Among these various causes the one most commonly met with, or I should say, the one most likely to be met with—since it assuredly is uncommon—is pernicious vomiting. We have in our *materia medica* remedies which, when properly applied, enable us almost invariably to relieve this troublesome accompaniment of pregnancy. But, for reasons unknown, we sometimes fail, or the case is not brought under our care in time to avert with medicines the serious symptoms which make the more active measures imperative. Within six months I have seen two cases of intractable vomiting, in both of which the uterus was emptied by surgical means, and in one of which, in spite of this measure, death occurred.

CASE I.—the first patient was Mrs. R., the wife of a physician, in her third pregnancy. Has had one living child. In previous pregnancies she had suffered inordinately from vomiting, and this one began in the usual manner. Nausea was extreme from the beginning, and increased as the pregnancy advanced. The vomiting finally became so extreme that little food could be taken and the patient became extremely weak. On one occasion, while retching, she felt something give way, and immediately noticed a discharge of water from the vagina. It was believed that the amniotic sac ruptured at this time, and that the death of the foetus dated from that moment, inasmuch as the nausea and vomiting were much worse thereafter, being exceedingly prostrating and almost deathly in their intensity. The patient became so exhausted that continuation of pregnancy seemed a severe menace to her welfare. Remedies carefully selected did no good. The patient was in such an extreme state of prostration from inability to retain even the blandest nourishment on the stomach, that, with the consent of the husband and the strong desire of the patient herself, preparation was at once made for the operation, which was proceeded

with according to the method which I shall recommend, and accomplished without serious difficulty. No fever followed the operation, and involution was perfect. As the patient's stomach was very weak food was given sparingly at first, but there was no more nausea and she quickly recovered.

CASE II.—In contrast to this case was another which I saw in consultation with Dr. P. H. Mason, of Peekskill. I was called with the expectation that abortion would have to be induced unless I could hold out a prospect of speedy relief from remedies. This I could not do, and the operation was performed, as will appear in the history. The patient was Mrs. C., aged 22, weight 150 pounds, healthy, rugged, strong. Married in April, 1896. Menstruated May 18th for the last time. Conception supposed to have taken place June 1st. Began vomiting last week in June, gradually and steadily grew worse. Could retain little if any food during the month of July. Second week in August went to the seashore, and was slightly better for a few days—when nausea and vomiting returned worse than before. Returned home August 25th. Dr. Mason saw the patient for the first time August 27th, when he obtained the foregoing history. Patient was then in an emaciated condition; estimated loss of flesh forty pounds. Eyes sunken in, cheeks hollowed—could hardly walk. After trying a few well-known and generally effective remedies, Dr. Mason stopped attempting to feed by mouth and ordered rectal enemata of liquid peptones, beef juice, etc. No improvement in the patient's condition resulted, and on the following Tuesday, September 1st, he resolved to empty the uterus; patient was then vomiting coffee-ground liquid of faecal odor.

I saw the patient at 1.30 p.m. September 2, 1896. Her eyes were sunken, with dark rings under them; the tongue was coated and breath offensive: occasionally she vomited a dark fluid mixed with frothy mucus. Her pulse was 124 to 130; no fever; surface of body was cool. There was some tenderness of the epigastric region and abdomen; no tympanitis; scanty movements of the bowels had taken place from time to time. The case presented the characteristic signs of exhaustion from long-continued vomiting, and from the history the conclusion was inevitable that the condition was due to the pregnancy. I proceeded to the operation of emptying the uterus

as rapidly as possible. The patient was placed under ether and carried to the table. The external genitals were shaved, and the parts, external and internal, were rendered thoroughly clean. The diagnosis of pregnancy was verified by the usual physical signs. A volsellum was placed in the anterior lip of the cervix and the uterus drawn down. The Goodell dilator was introduced easily, so that the tip of the blade passed just within the internal os. Dilatation to the extent of five or six centimetres was easily accomplished. There was no such rigidity of the internal os as we find in some such cases. I introduced a sound, which passed in about twenty-five centimetres (five inches). This was followed by the placental forceps, which, after passing the internal os, were opened slightly and pushed up into the uterine cavity; the blades were then closed and withdrawn, and the placenta was easily removed almost entire. The foetus was removed in pieces, and the uterus then thoroughly curetted and washed with a hot bichloride solution, 1-5000. After assuring myself that it was perfectly clean, I packed the uterine cavity lightly with iodoform gauze and then packed the vagina. There was no unusual amount of blood lost during the operation.

The patient was put to bed and hot bottles placed around her body. A hypodermic of strychnia, 1-60th of a grain, was given. The pulse was not weaker than before the operation. As the patient began to come out from the ether she vomited considerable black fluid, but this renewed vomiting was attributed to the ether, and it was expected that the vomiting would cease. The husband was encouraged to expect improvement, and the physicians in attendance confidently expected that such would be the case. The operation did not take more than twenty minutes, and the patient was left with the nurse at four o'clock. She rallied and seemed comfortable for awhile, but at eight P.M. she again began to vomit black fluid of a faecal odor; prostration became more pronounced, and at 12 o'clock she had a convulsion, became unconscious and died half an hour later. There was no haemorrhage after the operation.

This was an extremely sad case, and the termination was wholly unexpected. The question naturally arises, would not the result have been different had an operation been undertaken at an earlier period? Another question which arose in my

mind when I heard of the patient's death was this: Could there have been another cause for the symptoms than that which was diagnosed? Could intestinal obstruction have existed and been the cause of faecal vomiting, exhaustion and death, and not the pregnancy, as supposed? I think this suggestion must be answered in the negative, as the patient had been vomiting more or less for two months before she was seen by her attending physician; she had lost thirty or forty pounds in weight, and could retain little if any food during the month of July. During the last two weeks in August she retained very little food, and for one week of that period, while under Dr. Mason's care, she could not retain a mouthful of anything—not even a teaspoonful of water; during the last week she was fed by rectal enemata altogether. The usual signs of intestinal obstruction were not present. This affection comes on suddenly in the midst of good health. Pain is the first symptom, and is agonizing, and vomiting appears almost as soon as does the pain. There was no tympanitis, no fever and no signs of peritonitis. The disease lasted too long to be due to any such cause. The only conclusion possible is that the long-continued excessive vomiting had produced such an extreme state of exhaustion that the patient could not rally after the shock of a comparatively minor operation.

CASE III.—A third case of induced abortion for recurrent epilepsy brought on by pregnancy after an apparent cure. This patient was seen in consultation with Dr. W. M. Butler, of Brooklyn. The operation was performed after consultation with three physicians. The same methods were pursued as outlined in the preceding case. The operation was easily accomplished, and not a single unfavorable symptom occurred.

As regards the method of inducing abortion, the proceeding which I have described above would seem to be in every way the most satisfactory. It is at once surgical, clean, complete and without danger, if done carefully.

There is another method which will usually result in the expulsion of the intact ovum. This is the catheterization of the uterus. This is by means of a small, solid bougie, about No. 12 French, and a very flexible tip. The instrument is sterilized, and so is the genital canal and the instruments which are employed in its use. The bougie is introduced into the os and

then pushed gently into the cavity of the uterus as far as it will go, being careful not to rupture the membranes; it is held in place by inserting into its external end a catheter stylet which has been bent to an acute angle, and is retained in position by the attachment to its other end of a tape tied about the waist of the patient. Iodoform gauze should be packed in the vagina and about the os uteri. Then 15 or 20 minims of fluid extract of ergot may be given every four hours. If this does not bring on uterine action the bougie should be removed, cleansed and reintroduced. If the ovum still remains intact and the uterus is not stimulated to contraction, it may be assumed that the uterus is not responsive to excitation by this means, and other measures must be employed. A method which is equally effective, and more agreeable to the patient in that it involves no external apparatus for its retention, is the introduction of a sterilized soft-rubber catheter of the smallest size. By means of the uterine dressing-forceps, nearly the whole of the catheter may be introduced into the cavity of the uterus; it curls up inside of the uterus; the end which protrudes into the vagina is protected by a vaginal packing of iodoform gauze. The catheter may be left in place twenty-four hours, and reintroduced several times if necessary, each time sterilizing the vagina, cervix and as much of the interior of the uterus as possible. Haemorrhage, uterine contraction and expulsion of the ovum will usually follow within two or three days. The objection to the use of the bougie or catheter is that, even if successful, we can never be quite sure that the uterus is entirely empty. Fragments of placental villi may remain, which may give rise to subsequent haemorrhage or mild septic endometritis with its unfortunate sequelæ. The better way—when this operation is required—is to proceed antiseptically to dilate the cervix—empty the uterus with the placental forceps, curette, wash out, pack and drain with iodoform gauze.

*The induction of miscarriage*, that is, when the pregnancy is advanced to more than three, and less than seven months, is called for in persistent and uncontrollable vomiting, albuminuria with threatened eclampsia, haemorrhage from placenta praevia, hydramnion, some general diseases, such as tuberculosis, cancer of the cervix, tumors in the pelvis, and deformities of the pelvis of high degree (6 c.m.— $2\frac{1}{2}$  inches). During this period of

pregnancy the expulsion of the intact ovum is hardly to be hoped for. The dilatation of the cervix is a proceeding much more difficult of accomplishment than in the earlier months, that is to a degree sufficient to permit of the easy extraction of the foetus. If time is not a question to be considered, the best way to proceed is by the introduction of a solid bougie between the membranes and the uterine wall, under the same precautions as was mentioned earlier in this paper. As the uterus is by this time quite large, nearly the whole of the bougie may be introduced and held in place with gauze tampon. If the membranes are accidentally ruptured no harm will ensue, and indeed when pains do not come on within a reasonable length of time, it is best to rupture the membranes and support the diminished intra-uterine pressure by the vaginal tampon and the employment of ergot. If the exigencies of the case are so great as to demand immediate emptying of the uterus—as in case of haemorrhage—or threatened convulsions—forcible delivery by means of combined instrumental and manual dilatation of the cervix is the only procedure left open to the physician. *The induction of premature labor* is called for in all conditions menacing foetal or maternal life as well as those grave pathological or anatomical conditions of the mother that will, if the pregnancy is allowed to continue, be productive of grave degrees of dystocia. Among the causes may be mentioned moderate degrees of pelvic deformity (8 to 9 c.m.— $3\frac{1}{2}$  to  $3\frac{3}{4}$  inches), placenta praevia, threatened convulsions and those general diseases already mentioned under the head of induced miscarriage.

On the part of the foetus, induced premature labor may be called for in cases when the foetus has habitually expired during the last days or weeks of pregnancy, from any cause.

As to methods, when time is not a matter of importance, there is nothing so safe or sure as the introduction of the solid bougie between the membranes and uterine wall, reinforced, if necessary, by hot douches against the cervix. In one case seen by the writer when labor was induced prematurely for a contracted pelvis, the mother never having given birth to a living child, the bougie was aided in its action by the introduction into the cervix of a large tupelo tent—the whole being backed up by a gauze tampon. Labor will usually come on within twenty-four or forty-eight hours and proceed in the natural manner. When haste

is necessary, as in threatened convulsions or *placenta praevia*, manual dilatation of the cervix, rupture of the membranes and version, or the forceps, offers the best means at our command. I have tried the injection of sterilized glycerine into the cavity of the uterus according to Pelzer's method in two cases with success—but in view of later reports I would not resort to this plan in case the kidneys were affected. In all cases where it is possible forceps is preferable to version after full manual dilatation of the cervix and rupture of the membranes, on account of the fact that premature children are more apt to be born alive if delivered head first by means of forceps than when subjected to the rough manipulations of version. It may be said also that prolonged labor is equally prejudicial to them, and the sooner they are delivered after full dilatation the better.

I could cite many instances wherein all the above methods have been employed, but it is unnecessary to state more than the general rules which should govern one's action in these important and dangerous cases.

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#### ANHALONIUM (MESCAL BUTTONS).

BY E. M. HALE, M.D., CHICAGO, ILL.

SEVERAL years ago, in the columns of the *New England Medical Gazette*, I called attention to this singular member of the cactus family. From the incomplete experiments of Lewin on animals, it was thought it might form a valuable cardiac medicament. But recent experiments, which I will briefly detail, prove that its influence upon the heart is small compared with other cacti. Its sphere of action is mainly confined to the brain and spinal cord. Its affinities are *cannabis indica*, cocaine, coffeea, *hyoscyamus*, belladonna, and strychnia; yet it differs in a decided manner from all these drugs.

Lewin's experiments on animals show that it causes in them acute muscular spasms of varying intensity. In these experiments the alkaloid anhalonine was used. Lately, Drs. Prentiss and Morgan (*Medical Record*, August, 1896) used the hydrochlorate on animals and man, and were convinced that it was not

the active principle of mescal buttons. Two other alkaloids, muscaline and one not named, have been obtained. All three caused violent spasms of various kinds in animals, but it is evident that these experiments are of little value, because almost any drug will cause convulsions in the animals usually experimented on—guinea pigs, dogs, cats, and frogs. In man no spasmodyc symptoms have been caused by mescal, although the Indians take large quantities of it without any such symptoms.

This plant inhabits the valley of the Rio Grande, in Mexico, growing in barren and rocky soil. It has been used from time immemorial by the Kiowas and some other tribes of Indians in their religious ceremonies. These ceremonies are thus described by the ethnologist, J. I. Mooney: "The religious ceremonies mentioned usually take place on Saturday night. The male Indians having obtained their supply of the buttons, seat themselves in a circle around a large camp-fire, which is kept burning nightly. A button, after having been freed from the tuft of hairs, is put into the mouth, and after it is thoroughly softened it is rejected into the palm of the hand, rolled into a bolus and then swallowed. In this way ten or twelve of the buttons, as a rule, are taken at intervals between sundown and 3 A.M. Throughout the ceremony there is no dancing or singing, but the camp-fire is kept burning brightly and a continual beating upon drums is kept up by attendants. The Indians sit quietly in a state of reverie, the intoxication of the drug showing itself in the visions of color and other manifestations, which will be described later. They sit in this manner from sundown to noon of the next day. As the effect wears off, they get up and go about their work, it is claimed, without the slightest depression or unpleasant after-effects. Upon the day following the ceremony, they carefully abstain from the use of common salt with their food; this, it seems, for a religious reason, and not because of any incompatibility of salt with the drug or its effects."

The description of the manner in which the mescal buttons are used by the Indians was given to the writer by Mr. Mooney, who has several times partaken of the drug with them.

The *Therapeutic Gazette* for September, 1895, publishes six experiments (provings) made upon adults. They form a basis

for the following pathogenesis. I have not put in any symptoms obtained from animals, as I do not believe they would apply to disorders of the human body.

*Mind.*—A profound reverie seems to be a characteristic symptom, but all through the mind seems clear. They lose conception of time, the interval between words and sentences seems inordinately long (can. ind.). Frequently at loss for a word with which to express thoughts, with difficulty of enunciation. He seemed to have a double personality. A feeling of great distrust and resentment towards those who were making the experiments with him. He thought they were laughing at him, which made him desire to do violence to them. He was able to work with extraordinary facility and ease while under the influence of the drug. He had a sense of mental inferiority.

Like cannabis ind., it does not have the same effect on all persons. One of the provers felt "great mental depression and a sense of inferiority;" another "was perfectly happy, and experienced a sense of superiority and well-being." He wrote continuously an account of his sensations, but had difficulty in writing down his thoughts, so fast did they follow one another. (This prover had but few color visions.) Persistent ache and feeling of exhaustion in the occipital region, lasting several days, show a reaction from the primary stimulation of the brain.

*Clinical Remarks.*—The mental symptoms resemble those which precede some forms of insanity and cerebral paresis. Dr. D. W. Prentiss, in the *Medical Record*, August 22, 1896, reports the case of a man, aged 25, with neurasthenia of six months' standing. Three buttons were administered within an hour. This was followed by the characteristic color visions of the drug, and relief from the bodily and mental fatigue with which he had suffered for six months, and he declared that he "was himself again, cheerful and happy." On the next day, and several days thereafter, he continued to feel the beneficial effects of the drug. He has continued its use in dose of one-half a button (about 20 grammes) when he feels it to be necessary. It invariably relieves the sense of bodily and mental fatigue.

Another case: A lady aged 33, nervous prostration. The drug was administered in smaller doses with a marked bene-

ficial effect, mental and physical exhaustion was relieved and power to work was increased. There was no reaction.

Anhalonium resembles cannabis indica, coffeea and hyoscyamus in its action on the brain. From its effects on the vision it would be indicated in cerebral disorders when attended by irritation of the optic nerve.

*Head.*—The next day after taking the drug he was troubled with some disturbance of vision, *occipital headache*, sense of dual personality, "lapses of mind," but could work.

Persistent ache and feeling of exhaustion, "tired feeling" in the occipital region, lasting several days after the first effects of the drug had passed off, and was so severe that he could not work (*kava kava*, *cann. ind.*, *picric acid*).

*Face, Lips.*—They disincline to make the slightest movement. The eyelids droop, and they scarcely move their lips and jaws in articulating. They have great difficulty in talking, partly owing to a paralysis of the tongue and partly to slowness of thought (*gels.*).

*Smell and taste* are both blunted. He did not recognize cinnamon water by the sense of taste, but thought it different from pure water in some way. He could not tell whether or not the tincture of *asafœtida* was a perfume.

*Eyes.*—Dilatation of the pupils was well marked in every case. It commenced very soon after taking the drug, and continued for twelve or twenty-four hours. It was accompanied by some loss of the power of accommodation and drooping of the eyelids.

The most remarkable of the physiological effects of the drug is the production of visions. I quote the following experiment, which closely resembles six others. No other drug, not even hasheesh, causes such a color display.

A man, aged 27, took four and one-half mescal buttons between 9 and 11 P.M. He was nauseated till midnight.

"At 11 o'clock I retired to my room to prepare for bed. Before doing so, however, I noticed that on closing my eyes I could see all sorts of designs in brilliant and ever-changing colors. These visions were so pleasing that I at once decided to continue the experiment, and I placed the fourth and a part of the fifth button in my mouth. Then followed a train of delightful visions, such as no human being ever enjoyed under

normal conditions. My mind was perfectly clear and active; the power to concentrate my thoughts upon any desired subject was only slightly lessened; seated at my desk I could write of my sensations and experiences; stretched out upon the bed, with closed eyes, an ever-changing panorama of infinite beauty and grandeur, of infinite variety of color and form, hurried before me. By concentrating my thoughts upon various subjects successively, the nature of the visions could be determined, and considerable control exercised over the time that they remained in view.

"Perhaps the most pleasing of all the visions of the night were brought to view by my voluntarily thinking intently of the production of Kiralfy's 'America' as given two years ago. Indeed, during the passage of this and many other visions before my enraptured mental gaze, my pleasure so far passed the more ordinary realms of delight as to bring me to that high ecstatic state in which our exclamations of enjoyment become involuntary. I truly thought that I had experienced great pleasure upon many previous occasions, but the experience of this night was one quite unique in this regard in the history of a lifetime. The tendency of every feature of the experience to prove a source of pleasure was quite remarkable. Efforts to fix the attention upon some subject which should give rise to unpleasant vision resulted in the appearance of myriads of horrible crawling monsters and seas of grawsome forms of human face and body, which would cause the ordinarily sensitive human being to shudder. But under the influence of the mescal it merely added another item to the lists of the inexpressible delights of my remarkable night's experience."

A man, aged 24, a reporter. Seven buttons were taken powdered at 2 A.M., at 3 A.M. he was fully under the influence of the drug. At 7 A.M. he came nearly out of the influence of the drug (*i.e.*, the delusions of vision). At 7 P.M. he was free from all the symptoms. "The first sensations that followed my taking the drug came upon thoughtlessly closing my eyes. Instantly there sprang into the field of view a host of little tubes of shining light, down which green and red balls the size of peas were constantly rolling. The tubes of light bent themselves into the shape of letters, but they would spell nothing, and slowly curving themselves into grotesque shapes, began to

revolve rapidly, the green and red balls going in the opposite direction with even greater velocity. All the field of view between these silent wheels was filled in with a shifting mass of green. The colors were wonderful. They were the colors of the spectrum intensified, as though bathed in the fiercest sunlight. No words can give an idea of their intensity, or of their ceaseless, persistent motion; the figures constantly changed in form and color, but always remained a series of fantastic curves, revolving rapidly back and forth upon their own axis. The forms changed through rich arabesques, Syrian carpet patterns and plain geometric figures, and with each new form came a new flush of color, every shade appearing, from pure white to deepest purple. When the eyes opened and the light was turned up the visions faded like stars going out in daylight, and the room, tables, chairs, and surroundings came back into real existence and within reach of hands."

Another experimenter took four buttons between 10 A.M. and 1 P.M., weighing eleven and one-half grammes.

"Visions appeared upon closing the eyes at 1.30 P.M. in the form of tapestry designs in black and white. From this time until 3 A.M. on the following morning, whenever the eyes were closed, a panorama of beautifully colored objects, designs, scenes, dances, marches, etc., passed constantly before his imagination. The visions were at times under control of the will. The effect of music upon them was noted, and it was found to have no effect, except so far as the regular marking of the time was concerned. He preferred drumming to regular time upon a table, to the music of a piano. The effect of this was to make the men, women, and objects dance, or otherwise keep perfect time to the drumming, and greatly intensified the pleasant effect of the drug. It will be remembered that a constant beating upon drums is a regular part of the taking of the mescal buttons by the Indians." All objects seemed small and removed to a great distance, so that he needed assistance to bring a glass of water to his lips.

The visions were subject to suggestion. Upon being asked if he did not see this or that object, it immediately appeared. The visions appeared in paroxysms, and could be precipitated by turning down the light.

*Clinical Observations.*—With the exception of the peculiar

visions, mescal greatly resembles gelsemium. Both cause confusion of light, dimness, etc., from paralysis of the muscles of accommodation. But the blindness of gelsemium is in sharp contrast with the brilliant phantasmagoria of mescal. Many of its ocular phenomena resemble those of cannabis indica. How valuable this drug may prove in disorders of vision remains for the oculist to determine. As the visions are doubtless caused by a stimulation of the visual centres in the brain, it may prove that it will have no value as a homœopathic remedy in any localized disease of the optic nerve; but it may prove of value in some cases of cerebral diseases or insanity, accompanied by visual hallucinations.

*Gastric Symptoms.*—The only symptom noted was nausea, but this may have arisen from the nauseous taste of the drug. As no after-effects, such as nausea and vomiting, were observed, probably it does not irritate the stomach. No effect on the intestinal canal was reported.

*Urinary and Sexual Organs.*—No symptoms have yet been observed.

*Heart and Circulation.*—When Lewin made his experiments on animals with anhalonium, it was supposed that it resembled cactus, but later experiments seem to show very little resemblance. The heart's action was at first rendered more slow and somewhat weaker in quality. This was followed by a rise to the normal in quality and rapidity. In the cases where the muscular depression was greatest, slight, if any, depression of the heart was present.

In animals killed by the alkaloids of mescal, the heart beat some time after respiration ceased, and finally stopped beating in diastole (cactus causes the opposite condition).

*General Symptoms.*—Extreme muscular depression; they do not want to stir or move; all the body seems relaxed.

Dr. Prentiss says, as a result of his observations: "More or less depression of the muscular system was observed in every case. It ranged from a feeling of lazy contentment to marked muscular depression. Whether this sedative action is caused by a depression of the nerve centres, peripheral nerves, or their nerve endings, or of the muscular fibres themselves, we are at present unable to state; but from concomitant nervous effects we are inclined to the belief that it is due to depression

of the nervous system and not of the muscular fibres themselves."

All provers experienced a peculiar symptom appearing just before the visions appeared, namely, "a fine tremor in the lower extremities." Directly afterward extreme muscular weakness set in. "They became unable to walk without assistance, and could with difficulty maintain the sitting position. All the voluntary muscles were affected; they were limp and flaccid; they could not move their lips in talking, and at times were unable to speak above a whisper."

Partial anaesthesia of the skin was present in three cases, appearing when the effects of the drug began to wear off. In one case the respiration seemed difficult, but was probably due to weakness of the muscles concerned in that act.

Prentiss reports a case of "chronic bronchitis with asthmatic attacks," in which an irritating cough kept the patient from sleeping. A piece of mescal, the size of a pea, from the centre of a button, was dissolved slowly in the mouth, with speedy relief from the cough, allowing him to sleep all night. This relief followed every nightly dose for months, but did not cure. It was doubtless due to a local sedative action, similar to that of codiene, *hyoscyamus* or *lactucarium*.

*Pharmacology.*—The two preparations which should be used in practice are the tincture prepared from the powdered "buttons" and a trituration of the same.

Neither alkaloid represents the medicinal value of the drug. It is always best to use the whole drug, unless the alkaloid or other active principle actually represents it entirely, which it rarely, if ever, does.

Parke, Davis & Co., of Detroit, are the only manufacturers who prepare the tincture of anhalonium in this country. If there are others, I am not aware of it.

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**BROMIUM IN THE RESPIRATORY ORGANS.**—It is indicated in either diphtheritic or idiopathic croup. It is rarely called for in the early stages; but when the febrile symptoms have subsided, the patient is weak, perspiring, has a hard, tight cough, which is spasmodic, with suffocative attacks and sometimes rattling of mucus in larynx; the element of spasm is to be considered a characteristic of the drug. Bromine follows well after iodine. Spasmodic croup symptoms, starting up as if choked, greater when drinking; every inspiration provokes cough. Asthma in suffocative attacks; it seems as if the breathing were hindered by spasmodic constriction. In pneumonia, for suffocative attacks; cannot expectorate. Asthma greater at sea.

## HEART-CLOT AND PULMONARY EMBOLISM—SAD EXPERIENCES.

BY J. M. LEE, M.D.,

Surgeon to the Rochester Homeopathic Hospital.

(Read before the New York State Homeopathic Medical Society, September 23, 1896.)

IT is not my intention to indulge in an extensive treatise of the subject, but simply to briefly outline the more practical features of the malady, and recite such experiences as may serve as illustrations. We will not speak of those thrombi which frequently form during the closing hours of life, and may be known as cadaveric heart-clots, but will confine our attention solely to those ancient thrombi which have more or less definite clinical characteristics and terminate life independently of other causes.

These fibrinous clots differ from ordinary blood coagula chiefly by their density and color. The red corpuscles do not enter into the composition of the thrombus; it is apparently made up of pure fibrin and white cells, has a buckskin-gray color, and the upper surface is worn smooth by the current of blood. The part which adheres to the heart substance is rough and accurately conformed to the cavity from which it springs. This, in most cases, is the right ventricle, and the clot is entangled with the tendinous cords of the valves and muscular columns of the heart, and frequently grows up into the pulmonary artery.

In other cases the seat of the disease is in the auricle, and the growth spreads over the tricuspid valves and completely disables them, so that, when the auricle contracts, the blood passes backward and thus gives rise to the pulsation in the jugular vein occasionally observed. These growths are almost always found on the right side of the heart, though sometimes on the left, but not sufficiently large to cause death.

Heart-clot may be present for a week or two, possibly longer, and the patient suffer but little inconvenience. As to the duration of their existence no one can determine, as no signs or symptoms are present until their development is well advanced. Finally, there is more rapid growth, and life is quickly ter-

minated. At the post-mortem alone one may be reasonably certain as to their duration by their consistency: If the clot be very tough, elastic, and difficult to loosen, it is probably one of several days' or possibly weeks' development. If, on the other hand, it is less dense and readily torn, in fact almost friable, it may be considered of very rapid growth.

The causes which are operative in this dangerous disease are both medical and surgical. Among the former may be mentioned the morphine habit, colliquative sweats, diarrhœas, cholera, anaemia—chronic or acute, as from loss of blood at the lying-in state—or in other diseased conditions in which the fibrin is greatly augmented. Surgically, heart-clot is chiefly due to haemorrhages, shock and sepsis. The symptoms which announce the onset of the malady are not often sufficiently marked to permit one to make a positive diagnosis, yet they are reasonably suggestive, and enable the surgeon to suspect the condition. Perhaps the chiefest group of symptoms, and the only one which is valuable, is the praecordial anxiety, accelerated respiration, syncope, and rapid, almost imperceptible, pulse. The patient desires to be fanned constantly, and gasps for breath. If cardiac thrombosis follows an abdominal operation serious enough to entail considerable shock, it probably will be impossible for the surgeon to differentiate it from that disease.

Intra-abdominal haemorrhage and septic peritonitis can be more readily diagnosed: The former may be known by deathly pallor of the countenance, and cold sweat with which the body is often bathed, as well as the peculiar dimness of vision frequently observed in haemorrhages. If the case be serious enough to require a glass drainage tube, of course it will announce the presence of blood. If the latter disease, septic peritonitis, is present, there will be tympanitis, and vomiting at first attended by severe retching; it will soon become less difficult, and finally the patient will merely spit out the fluid without effort. In the beginning the vomited matter may be watery, tinged with bile, but it rapidly becomes darker, and finally assumes a blackish appearance as if mixed with dark blood.

Pulmonary embolism may result from two causes: Arteritis of the pulmonary artery, or emboli carried from thrombi of the systemic vessels, usually the large veins of the legs or pelvis. The causes which give rise to the thrombosis and arteritis are

numerous, and we will not take up the time of this society for their discussion. My greatest surprises, gravest doubts and saddest experiences have been associated with heart-clot and pulmonary embolism. The cases are so fresh in my mind that I now, as before stated, call up the salient points to illustrate the subject.

Nine years ago this present autumn, I performed an abdominal hysterectomy by the intra-abdominal method, on Mrs. L., at her home in this city. She was an estimable lady, and I was doubly anxious to secure for her a speedy and satisfactory recovery. She was in sound health, so far as known, yet a few days before the operation I was informed that she suffered an attack of cardiac dyspnœa. It passed off, and at the time of the operation nothing unusual was discoverable about the heart. She took her anaesthetic exceptionally well, and the uterus was removed with the loss of but little blood. She progressed without complications of any description for three days, and just as we were about to announce her freedom from danger, she was taken suddenly worse, with difficult and rapid breathing, sighing, and great anxiety. The respirations ranged from 40 to 60 per minute; pulse, 180 to 160, almost imperceptible at the wrist, and death closed the scene on the fourth day.

I was unable to assign any cause for the sad occurrence, and the husband kindly consented to have an autopsy performed, which was conducted by Coroner's Physician Wolcott, now President Wolcott, of this Society. The parts about the operation were in good condition, there was no peritonitis, and the organs were in a healthy state. The heart, however, contained an ante-mortem clot in the right side, which completely disabled the valves and grew up into the pulmonary artery for an inch or two, and was regarded as the cause of death. It is my opinion that this disease antedated the operation, and the loss of blood attending it caused a more rapid growth of the clot.

Mr. J. N., of this city, another case of this character, complicated a serious attack of appendicitis. The gentleman was under the care of an allopathic physician who called me for consultation. The patient had marked dyspnœa and tympanitis. His greatest desire was for fresh air, and it was necessary to fan him constantly. He was sent to the Rochester City Hospital for operation, and while taking the ether, he suddenly became

asphyxiated and died while in the second stage of the anaesthesia. At the time, death was attributed to the ether, but the autopsy on the following day disclosed a very large fibrinous clot of the heart which had completely disabled the valves and nearly occluded the pulmonary artery.

Mrs. M. B., Geneva, N. Y., patient of Dr. J. C. McKenzie, was sent to me by her physician, for hysterectomy for the relief of cancer. She was a fleshy woman with lax fibre and rapid and feeble heart's action, and what was still worse, she was for twenty-seven years addicted to the morphine habit. During a portion of this period she indulged in the greatest excess with the drug and much of the time took thirty grains in each twenty-four hours. When she was received she took twelve grains a day. She suffered from cancer of the cervix uteri, which was evidently hereditary, as her grandfather and uncle died with cancer of the face. Vagino-abdominal hysterectomy was performed July 9, 1896. Although the broad ligaments were not involved in the cancerous growth, they were friable, and the ligatures readily cut through them; slight traction caused their attachments to give way and there was profuse oozing. On account of the long, narrow vagina and the inability to depress the uterus, it was thought safer to complete the operation by the abdominal route, so she was placed in Trendelenburg posture and the parts quickly reached from above. As the knife passed down through the abdominal tissues, they were found to present the appearance of acute anaemia, as sometimes seen in cases of severe and protracted haemorrhage from fibroid tumors. When the retractors were applied to the wound and the broad ligaments separated, the uterus was removed and we found even more formidable difficulties than were encountered from below. The bladder was greatly dilated and hypertrophied, due to loss of functional activity from the use of morphine, and projected into the wound and shut off the view. The same was true of the rectum and sigmoid flexure of the colon. Her bowels had been constipated for days at a time, over a period of more than a quarter of a century, and developed a condition which more nearly resembled in size a stomach than a rectum. All the cut surfaces kept up a constant oozing, and it was necessary to sew them together by continuous sutures before the haemorrhage could be

arrested. The very deep wound, with the bladder and rectum projecting into it from before and behind, formed a barrier to the ready use of the needle, which delayed the operation considerably. The blood lost was not more than is often followed by recovery, yet it was evident very early in the operation that she would not survive what appeared to be shock.

It is well known to us all that patients addicted to chloral, the bromides and morphine, bear shock badly, and we always dread to operate upon them; yet in this case the only hope of life lay in prompt surgical treatment. Just before she was removed from the table, she became much worse, and despite stimulants and forced respiration, she died two hours after the operation. It is also well known to us that the habitual use of morphine predisposes to the development of cardiac thrombosis, and it is not improbable that in this case there was heart clot prior to the operation, which accounted for the high pulse and apparent shock, and terminated life; but as a post-mortem was not held, one cannot state this as a positive fact.

Mrs. S. C., Horseheads, N. Y., patient of Dr. W. E. Colgrove, had ovarian abscess and universal adhesions of the organs of the pelvis, which concealed the uterus. The operation for the removal of the diseased tubes and ovaries was tedious, difficult and protracted. Several superficial wounds of the intestines were closed, as well as a large opening in the rectum at the bottom of the pelvis where the abscess had discharged.

She suffered much shock, but twenty-four hours afterward completely reacted, and remained in good condition for some time, when she was again prostrated with symptoms which might readily have been taken for secondary shock. Before I observed the change in her, Dr. Button, of the house staff, had diagnosed it as cardiac thrombosis, in which I concurred, and the autopsy performed by Drs. Woodman and Conklin, in the presence of Dr. Button and myself, verified the diagnosis. The clot was, of course in the right side of the heart entangled among the *chordæ tendineæ* and *columnæ carneæ*, and completely spread over the valves of the heart and disabled them.

Mrs. C., Oswego, N. Y., patient of Dr. Keeney, was admitted to the hospital, May 25, 1894, with a diagnosis of myofibroma, which grew from the lower segment of the uterus and was badly complicated by talongiectasis.

Fourteen months before, I performed ovariotomy, at her home, for the arrest of haemorrhage and the growth of the tumor. It did not prove successful, and as the lower segment of the uterus expanded greatly and caused unbearable disturbance and pain of the pelvic organs, she applied for relief through hysterectomy.\* Although she was informed that her chances for recovery were not more than 50 per cent. she chose the operation rather than to longer endure the suffering. The capillaries were greatly enlarged and the ovarian and uterine vessels were dilated to the size of the finger. Notwithstanding the tissues were usually secured before they were cut, she lost much blood, and intra-cellular injections of normal salt solution were freely used. Her pulse came up and she did well during the day and evening of the operation, but sank during the after part of the night, and died the following day with symptoms of heart-clot. The autopsy, by Dr. Hoyt, revealed the presence of a very large, white, brittle, fibrinous clot.

Mrs. M. H. was admitted to the hospital April 18, 1892, with myofibroma of the uterus. She had a weak heart's action, yet there was no organic disease discoverable. Ovariotomy was performed for the relief of the tumor, and she did remarkably well for a week, and was thought to be out of danger, when symptoms of heart clot developed, and she died on the eleventh day. An autopsy showed death to be due to heart-clot.

A case which carried even more disappointment was that of Mrs. T. F., of this city, patient of Dr. Sumner, who entered the hospital July 17, 1895. Total extirpation of the womb by the abdominal route was performed, and there was no shock from the operation. She progressed without complications and with unusual evenness for twelve days, and had received permission to sit up, when suddenly a messenger announced that she was in a critical condition. Both Dr. Sumner and myself went immediately to the hospital, where we found her cyanotic and gasping for breath. In spite of the best efforts to save her, she succumbed thirty minutes after the inception of the attack. Pulmonary embolism was the probable diagnosis, and pathologist Hoyt, of the hospital, verified the condition on a post-mortem examination made in the presence of her family physician, the house officers and nurses of the hospital.

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\* See cut of tumor, Fisher Macdonald *Surgery*. Fig. 2, page 1286.

Probably the saddest case of them all was that of Mr. J. D. Victor, of New York. While at the annual picnic of his church, he was accidentally shot in the phalangeo-metatarsal joint of the great toe, by a young friend who was carelessly handling a Flobert rifle. Nothing was done for three days except to probe for the bullet, and, as it could not be located, he was brought to the hospital by his clergyman and placed under my care. Chloroform was administered, a Martin's bandage placed about the leg, and the missile extracted. As the knife divided the tissues he winced, and just before the Martin's bandage was removed he threw his hand off from his chest, which showed that at no time was he profoundly anæsthetized. A vessel in plain view was tied, and the Martin's bandage removed. The blood quickly returned to the wound, and three other vessels were secured, when the anæsthetizer announced that he was not breathing. Artificial respiration was resorted to and the man was resuscitated, as was supposed; yet his respirations were short, and unlike those I had observed in similar conditions. I went back to stitch up the wound, and he again ceased to breathe. I repeated the artificial respiration and resorted to all known means to restore him, but he did not respond. As he vomited just before the first suspension of respiration, it was thought that possibly some foreign body might have reached the larynx, and, although there had been no signs of this accident, tracheotomy was performed as the last resort, and artificial respiration continued by O'Dwyer's artificial respiration apparatus. It was useless, and he died partially cyanotic. He was a strong, healthy young man, and, of course, his death was at the time attributed to chloroform, but the autopsy showed clearly that this agent had nothing whatever to do with it; for when the heart was reached and declared sound, a search was made in the pulmonary artery, which was found filled and distended with fresh clots. The vessel itself appeared to be normal until we reached a point near its bifurcation, where two ancient thrombi developed. These were not sufficient to completely occlude the artery, and it was apparent from their tough, fibrinous character that they were of several days' development. It is likely that the sepsis from the wound was a factor in the formation of the thrombi; then, when Martin's bandage was placed about the leg, there was enforced stasis of the large

veins, and, as a result, fresh clots formed. When the bandage was removed, they were immediately carried by the venous current to the inferior vena cava, thence through the right side of the heart, and so on to the partially obstructed bifurcation of the pulmonary artery, which they completely plugged for about an inch and a half, and caused instant death by cutting off the supply of blood to the lungs, or, in fact, arrested the circulation.

It may appear that I have had more of these cases than should fall to the lot of a single surgeon, or that the malady is common; but facts do not warrant such conclusions, as heart-clot and pulmonary embolism have been observed only eight times in my practice, or once in every five hundred and eighty-five surgical operations. Again, it is my best judgment that a very large per cent. of the deaths ascribed to shock are really due to heart-clot or pulmonary or fat embolism. I am aware that many of the best authors speak of secondary or delayed shock. This is a condition that, at one time, appeared plausible to me, but of late I have become more sceptical in regard to it, and now I do not believe that such a thing exists at all. When a patient reacts from the depression which follows an operation, I believe he will not again be seized with shock; but that in all such cases the reappearance of symptoms which resemble that malady are due to the intervention of heart-clot, pulmonary or fat embolism, or else acute anaemia from haemorrhage or septic peritonitis. I am also convinced that many deaths which occur upon the operating table during the administration of chloroform or ether are by no means always due to these agents, but frequently to the thrombotic obstruction to the action of the heart or the plugging of the pulmonary artery.

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#### ALETRIS FARINOSA, A TYPE OF THE VEGETABLE BITTERS—THEIR VALUE.

BY J. HEBER SMITH, M.D., BOSTON.

(Read before the Massachusetts Homœopathic Medical Society, October 14, 1896.)

THE drugs to be mentioned are introduced but cursorily, since they need to be more carefully proved on the well, according to the methods adopted by the homœopathists. Classed

as astringents merely, their utility is being called in question, and should the scientific challenge of the modern school of thought not be answered speedily by clinical tests, carefully reported, and based on the most trustworthy experiments, they will be shorn of their ancient prestige.

Astringents are commonly defined as local and remote. Local astringents, primarily, at least, cause contraction of tissues to which they are applied, upon the living organism, and constantly upon dead tissues containing albumin.

Remote astringents are supposed to act on internal organs after their absorption into the blood. But the term remote would seem, in the light of recent experiments, to be applied to astringents without sufficient warrant. It was formerly supposed that their action was partly due to their exercising a contracting force upon the blood-vessels going to any part of the body, thus lessening the supply of fluid to the affected organ, as well as astringing the investing tissues. Surely this would seem a most admirable and wise election, if true.

Experiment has hinted that nitrate of silver and acetate of lead appear to possess systemic influence as astringents, in so far that these salts have been shown to manifest a stimulative action on the nerve-cells of the circulatory system, perhaps through their homœopathicity to vaso-motor paralysis. But the iron perchlorid and alum, after their exposure to the alkaline fluids of the body, do not contract the internal blood-vessels, and it has been shown by Rossbach that tannic and gallic acid actually dilate these vessels. He concludes, as quoted by Brunton, that the astringent action of these acids, when absorbed into the blood, must therefore be exerted upon the tissues, whenever they prove effective in the treatment of hæmoptysis, hæmaturia and nephritis. Strümpfell, after many clinical trials of tannic acid in nephritis, denies its efficacy in controlling the circulation in the kidneys, suggesting other means for lessening blood-pressure.

Inasmuch as an excited and powerful action of the heart tends to increase the general blood-pressure, it should seem of prime importance in hæmorrhage, that advantage be taken of the well-known action ofaconite in diminishing the force and frequency of the heart-beat. Numberless clinical tests, especially in hæmoptysis, justify our preference for aconite.

*Aletris Farinosa*.—Star-grass, Colic Root. Perennial; found from New England to Georgia, and west to Missouri; abundant at the south and confined to dry and poor soil; unknown to rich limestone soil and alluvial regions.

*Preparation*.—Tincture from the fresh root by maceration with pure alcohol; trituration from the dried root. Its rhizome holds a resin intensely bitter, though free from tannin, soluble in alcohol and partly so in water. It is more bitter than aloes, gentian or quassia.

Its generally recognized properties seem to have been derived from eclectic sources, principally from 1820–1870. It has long been a favorite remedy in our western states for women suffering from muscular atony, with prolapsus uteri; habitual tendency to abort; premature and profuse menses; obstinate vomiting during pregnancy; disgust of food; obstinate indigestion, with inveterate constipation as from rectal paralysis.

Its common uses, other than as a simile, are as a so-called tonic, emetic, purgative for colic, and for dropsy, chronic rheumatism—in fluid extract, decoction and tincture. Dose about 5–10 drops of tincture.

*Provings*.—Dr. J. N. Wing (*American Homœopathist*, March, 1885) reports six interesting provings republished in the *Cyclopædia of Drug Pathogenesy*. One prover, a woman, who began with 80 drops of the tincture, had for years suffered from a profuse yellow, malodorous leucorrhœa, and which had increased during the two months preceding the proving, noticed that on the second day of the proving the discharge was less, and on the third day almost imperceptible. It was shown to be capable of exciting hypogastric pains, excessive nausea, vomiting and giddiness, with fainting; constipation; “gone feeling at the stomach;” and sense of utter muscular weakness.

*Therapeutic Uses*.—It has been found, without doubt, an excellent remedy for certain ailments of pregnant women, especially for threatened abortion from incontrollable vomiting, with excessive nausea.

Enciente women not infrequently crave some bitter extractive principle, for some unknown cause, as many of you may have learned. From my earliest childhood, until past thirty years of age, I carried a probably prenatally induced periodical return, each autumn, of a strong craving for the large bitter

acorns, of which I laid in a great store, during several weeks in each recurring October. I was not informed until past twenty-five, that my mother had been unable to keep any other food upon her stomach during the last two months of gestation with me, save white-oak acorns, of which she ate great quantities, with relish and entire retention of strength, from October until December, the month of her delivery. Her craving for this kind of fare never again returned, but my own has not wholly gone after more than half a century, though the strange longing grows each year less and less imperative. I was the youngest of her seven children, with none of whom did my mother have any experience like this, neither had any of the rest any peculiar craving whatsoever.

Before closing permit me to call your attention to a few points about this tree, the oak, so famed in prose and poetry, from the point of view of the therapist.

*Quercus alba*, the common source of tannin (querci-tannic acid), is classed as an astringent tonic. Its uses are similar to tannin, from ancient times, for haemoptysis, epistaxis, uterine haemorrhage (by bark pessaries); for injections for leucorrhœa, gonorrhœa; topically in prolapsus ani, haemorrhoids, ulcers; as a gargle in prolapsed uvula and pharyngeal catarrh (an analogue here of geranium maculatum).

Workers in tan vats are said to be exempt from intermittents or phthisis.

Many of the drugs classed as bitter "tonics" are viewed as anti-periodic, antipyretic, antiseptic and capable of arresting ferment. Among these may be mentioned, in passing, the salicaceæ (willow family), the source of salicin (as well as of tannin), used in acute rheumatism, to lower the temperature in fevers, to reduce arterial swellings in intermittents, and applied externally for the relief of gangrenous wounds, fissures, cancers and burns.

Tannic acid from nut-galls enters the blood under the form of gallic acid, into which it is changed in the digestive canal, and its remote effects, according to Dr. Stockman's chemical argument, are due to this change to gallic acid, in controlling haemorrhage from the stomach and bowels.

M. Arthaud claims that the effect of tannin is superior to that of creasote in tuberculosis, from observations made on 2000 cases with this method of treatment.

Finally, I beg to invite your attention, very briefly, to another of the bitter vegetable remedies, which has become my favorite in treating the atonic dyspepsia and anorexia of sewing-women. I refer to the *picranæna excelsa*, or quassia, a native of Jamaica and Surinam. Its name is from Quassy, the name of a Surinam slave, who became noted for his many cures, with this bark, of malignant fevers. In 1756 it was taken to Stockholm, and soon became popular in Europe as quassia amara (Surinam quassia wood). Tannin is absent, notwithstanding the bitterness of this wood.

I can vouch for it, from extended experience, as a very satisfactory remedy in atonic dyspepsia, as stated before, with toiling and ill-fed sewing-women, especially when they have lost all appetite and strength. With a few cent's worth of the chips of quassia, kept standing in the patient's daily drinking water, I have often brought about complete restoration of health to these unfortunates.

Quassia is successfully given as an enema of the infusion for ascarides of the rectum, and internally, by the mouth, for lumbricoid worms—dose, 5 to 10 minims.

Excessive doses of quassia are capable of exciting headache, nausea, vertigo, cramps and even narcosis.

Regarding the administration of these bitters, my own experience has been most satisfactory from the use of the first or second decimal dilution, taken about thirty minutes before meals.

If there be any among my hearers who are asking what have all these therapeutic references regarding comparatively unknown drugs to do with homœopathic *materia medica*, suffer me to reply that in his marvellously erudite essay on belladonna, our own Hahnemann quotes in the introduction upwards of sixty writers who had treated of that remedy before him. As we approach the close of the era of our founder, let us seek to cultivate the same scholarly breadth of observation that so distinguished him.

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CUNDURANGO.—Is of use in very hard, painful tumors of the breast associated with ulcers in the corners of the mouth; this soreness and cracking in the corners of the mouth is considered characteristic of the drug. It has also been used successfully in stricture of the œsophagus, with burning pain behind it, where the food seems to stick sometimes. There is vomiting of food and induration in the left hypochondrium, with constant burning pain.

## THE OPERATIVE TREATMENT OF UTERINE DISPLACEMENTS.

BY HOMER I. OSTRUM, M.D., NEW YORK.

THE uterus can become displaced only through some defective action of the ligaments and structures which are designed to hold it in suspension in the pelvis. But in studying the pathology of uterine displacements, I think we are inclined to give undue prominence to *relaxation* of these structures, and not sufficient attention to *contraction* of the same structures, as a cause of malpositions.

It is possible for any one, or number, of the uterine ligaments to so contract as to cause the uterus to assume an abnormal position, but clinically I have found the *utero-sacral* ligaments the bands which, by shortening, most frequently hold the uterus away from its normal axis in the pelvis. And the more opportunities my operations upon the uterus afford me of examining that organ, the more the conclusion is forced upon me, that those ligaments which pass, from the *cervix-uteri* principally, to the sacrum, perform a very important function in maintaining the anatomical relations of the child-bearing organ.

All other structures that assist in this function, the broad ligaments, the round ligaments, and to a certain extent the vagina, though I confess to a considerable degree of skepticism as to the importance of this tube in holding up the uterus, are constructed with a view of accommodating themselves to the enlargement and change of position of the uterus during gestation. They are, therefore, not made up of the same permanent, endurable fibres that enter into the formation of structures, that are physiologically less changeable, and are affected by a greater variety of causes, than such structures.

The cervix and lower segment of the uterus, within a certain radius, change position during the rising of the pregnant organ, but they are the most fixed portions of the uterus, this degree of immobility depending upon the length of the *utero-sacral* ligaments. As a matter of fact, when these ligaments are normal, the uterus cannot fall, nor will it, unless held backward by adhesive bands or by the weight of the fundus,

becomes retro-displaced, but when the bands are contracted, the cervix and that portion of the organ to which they are attached are drawn against the sacrum. There thus follows either acute anteversion or one of the most intractable forms of uterine displacement, a high degree of retroflexion, which I have found to be always associated with contraction of the utero-sacral ligaments.

Further clinical observation leads me to see a relation between the frequency with which uterine retroflexion occurs, and the liability with which pelvic inflammation and its products become localized in the retro-uterine spaces. Following an attack of pelvic cellulitis, we almost invariably find contraction of the utero-sacral ligaments; indeed, so constantly is this the case that I have learned to depend largely upon this condition in establishing a diagnosis of previous attacks when no other local signs are apparent. The ligaments then exist as two tightly-drawn bands, leading from the posterior and lateral aspect of the cervix to the sacrum. They are frequently exquisitely sensitive, pressure upon them giving rise to a recurrence of the symptoms for which the patient sought relief. I have frequently found a severe attack of nausea to be induced by an examination involving pressure upon these contracted ligaments, and I think much of the suffering attendant upon an otherwise perfectly adjusted pessary is frequently owing to pressure upon these ligaments, which are liberally supplied with nerves from the inferior hypogastric plexus.

As a practical deduction from the foregoing observations, I believe that no case of uterine displacement associated with contraction of the utero-sacral ligaments can be successfully treated unless relieving that tension forms a part of the treatment.

With this theory before me, I have for some time operated on the utero-sacral ligaments as at least a preliminary procedure in all such cases. Frequently it is all that is necessary to restore permanently the position of the uterus, but not infrequently the relief of contracting bands is not sufficient, but must be combined with some measure having for its object holding up the uterus, the other uterine ligaments having become so far relaxed, atonic, as to require reinforcing.

Of all operations pointing to this end, I prefer securing the fundus to the abdominal wall. With it I have never failed to

obtain permanent anteflexion, and in those cases that have subsequently become pregnant, no interference with the rising of the uterus during gestation has been observed, or the natural course of child-bearing interrupted. The operation, in the hands of the abdominal surgeon, is easily accomplished and attended with little risk, but is, I believe, useless unless the uterus is first liberated from below. Neglect to do this is the cause of many failures to restore the uterus to its normal position by means of operations attacking the organ from above. Though I have little confidence in shortening the round ligaments as a means of holding up the uterus, I do think even that operation would score more successes if combined with a preliminary relaxation of the fibrous bands holding the uterus in the pelvis, and the cervix firmly against the sacrum.

In common with other operations for the relief of tension, cutting the utero-sacral ligaments requires skill in manipulation and a nicety of calculation.

I attack the ligaments through the vagina. After the same thorough aseptic local preparation that I exact for a vaginal hysterectomy, the vagina is opened and the cervix exposed. Frequently, with the condition calling for this operation, there is associated a greater or less degree of endometritis which requires curetttement. This having been done and the uterus packed, the perineal speculum is exchanged for one acting on the anterior vaginal wall, or, better still, a position which I have laterally adopted with benefit, the *reversed Trendelenburg*; that is, the patient is placed on her face, and the table worked into whatever degree of Trendelenburg's position is desired. This position throws the uterus against the anterior abdominal wall, and renders tense the utero-sacral ligaments.

If the vagina is at all capacious—and usually these patients have passed through all forms of local treatment, which tend to relax the vaginal walls—no speculum is required for the further manipulations.

The cervix being held, and slightly drawn down with a fine volsellum in the left hand of the operator, the degree of tension of the utero-sacral ligaments is easily made out with the right index finger.

The slight roll of tissue that marks the junction of the cervical and vaginal mucous membrane is then incised, and the

lower borders of the ligaments exposed. By gentle alternate traction on the uterus, and clipping with fine blunt scissors, a considerable portion of the ligament can be liberated without opening the abdominal cavity; but if the contractions are extensive, and involve the entire ligaments, the peritonæum is of necessity opened, as in vaginal hysterectomy. Such an extension of the operation offers an opportunity of examining the appendages, and removing any disease that may exist in them.

The extent of the operation will depend wholly upon the degree of the contraction of the utero-sacral ligaments and the bands of adhesions that may exist between the uterus and the sacrum, the result of pelvic cellulitis; always bearing in mind that the operation will fail of its object if the uterus is not made freely movable.

When the abdominal cavity is opened I drain, as in vaginal hysterectomy. After restoring the uterus to a rather accentuated normal position—to accomplish this it may be necessary to secure the fundus to the anterior abdominal wall—I pack iodoform gauze behind the uterus, between the raw surfaces made by the separation of adhesions and the relief of the contracted utero-sacral ligaments. The vagina is then lightly packed with gauze.

The after-treatment does not differ from that for vaginal hysterectomy. The gauze is removed with the aid of peroxide of hydrogen at the end of the seventh day, subsequent treatment consisting in a daily bichloride douche.

When the peritonæum is not opened, the treatment differs only in the extent of the packing required and the length of convalescence.

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#### CASES OF TUBERCULAR MENINGITIS CURED WITH IODOFORM.

BY W. J. MARTIN, M.D., PITTSBURG, PA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania,  
Philadelphia, September 30, 1896.)

ABOUT two years ago I had under treatment a child aged between one and two years, who had been sick for a week or more with some ailment exhibiting a great variety of symptoms; at

times the trouble would appear to be gastric, again cerebral, then as though due to dentition; there was always more or less fever, restlessness and sleeplessness. This was the first illness the child had ever had. The family history was good, no taint of any kind on either the paternal or maternal side, and the other children of the family, three in number, all living and well. I called in consultation one of our men whom I consider has no superior as a diagnostician. We went over the case carefully and thoroughly, but he could not agree with me in my opinion that the case was one of tubercular meningitis. It did not at the time he saw it seem sick enough. The case went from bad to worse and died. Then the doctor agreed with me that it had been a case of tubercular meningitis. If it had recovered he would have adhered to his opinion that it was not and never had been tubercular meningitis.

So it may be with my friends here when I report such a case as recovering under iodoform, you may question whether or not it was really tubercular meningitis. And well you may, for it is written in our most authoritative text-books that the disease is universally acknowledged to be always fatal, and cases of supposed tubercular meningitis making good recoveries are looked upon as examples of diagnostic errors. But (to quote Raue), "Is the disease always fatal?"

"Because there are no infallible means to distinguish during life between it and simple meningitis, those cases which have recovered and were claimed to be tubercular meningitis are simply set down as errors in diagnosis, the real proof—post-mortem—is wanting, and therefore, as in all such cases which come under the hands of these physicians, the post-mortem proved their diagnosis correct, they concluded that all other cases must likewise be fatal. Against this conclusion I allow myself modestly to protest. Might not a different treatment prevent post-mortem examination? And are all tubercular affections necessarily fatal? I have lost cases of tubercular meningitis to be sure, but I believe that I also, as well as others have, cured some. The prognosis is bad, that is true." And the reporting of a case cured may help in the cure of others.

My attention was first called to the subject of my paper by reading in the *North American Journal of Homœopathy* for February, 1896, an article entitled "Iodoform in Tubercular Men-

ingitis," by William S. Miner, M.D., of New York City, who, I am very sorry to say—for I knew him well—died of pneumonia a few days after his paper was published. His cases are described very minutely, and are very interesting, and I do not see how any fair-minded person could for a moment question that two of the three cases, all of which recovered perfectly, were tubercular meningitis. In these cases the iodoform was given by inunction, an ointment of iodoform and vaseline, one drachm to the ounce being used, about one drachm of this being very thoroughly rubbed into the shaven scalp twice a day. Iodoform in the sixth and second decimal triturations, a dose every two hours, was also given, and he thought he had the best results from the inunction.

Dr. Martel, in the *Revue Internationale*, reports seven cases cured by this method, he used an ointment of iodoform, 3ij. to vaseline 3ij., a half-drachm of which was rubbed into the scalp twice a day.

In his work on the *Practice of Medicine* our distinguished confrère, Dr. Goodno, says, that "Among remedies for tubercular meningitis iodoform stands at the head," that "It has produced symptoms indistinguishable from meningitis," that "It is customary with old-school physicians to shave the scalp and apply an iodoform ointment, but that the internal administration of the drug will probably do as much good."

Basing my faith on this, I applied the remedy in the second decimal trituration in the following case. I will not take up time describing the symptoms present, as you all know how multifarious they may be. I had been attending the child—which was the first and only child in the family, and previous health good—from the third to the eighth of February of this year, prescribing daily belladonna, as I could not see that any other remedy was as well indicated, but the child did not improve one whit. Up to this time, the fifth day of my attendance, I was "at sea" as to diagnosis, though I was becoming suspicious, but now the diagnosis was clearly enough tubercular meningitis. The temperature was 103°, at which it had been standing for three days. Iodoform 2x, four grains in a goblet half-full of water, a teaspoonful of this every two hours was prescribed. This was on the evening of February 8th.

*February 9th, A.M.—Temperature, 102°; child a little better.*

*February 10th, A.M.*—Temperature, 101; child decidedly better.

*February 11th, A.M.*—Temperature, 100; child decidedly better.

*February 12th, 13th, 14th and 15th.*—Child decidedly better.

During all this time the iodoform prescription was continued, and on the seventh day after it was commenced the case was dismissed cured, and has remained so to this time.

Another case is that of a babe fourteen months old brought to me August 31st, present year, had been sick one week under care of an allopath who changed his prescription every day. The symptoms I noted at this first visit were fever, no sleep, hot head; Rx belladonna.

*September 2d.*—The father reports the child sleeping all the time, he therefore thought it better; Rx sac. lac.

*September 4th.*—The report is brought that the child still sleeps much, but moves the mouth constantly as though chewing or sucking, bores the head back and rolls it from side to side. The child has been sick now about twelve days. My suspicions were aroused as to the likelihood of it having tubercular meningitis, but the symptoms being so marked for hellebore, I sent it with the request that they report in the evening. In the evening I saw the child late, in response to a call sent early, which I did not receive on account of being called out of the city, and found it in most violent convulsions, facial features distorted, eyes squinting, head retracted, neck and back stiff, automatic motion of one arm and leg and all that kind of thing. There was present a sign which some have claimed to be pathognomonic, that was when I drew my finger nail across the child's forehead a red line appeared and remained a few moments. I prepared iodoform 2x in water as in preceding case, with instructions to give a teaspoonful every hour. We all expected the child to die before morning, but it did not; on the contrary, when I made my visit the next morning I found that the spasms had almost ceased, the febrile condition was much moderated, and the child could again nurse. The iodoform was continued, the child improved steadily and rapidly, so that in one week from the time of commencing iodoform the child was discharged cured.

## A CASE OF BRAIN ABSCESS.

BY D. P. MADDUX, M.D., CHESTER, PA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania, 1896.)

MR. I.; married; æt. 38; by trade, an engraver; of excellent family history, and good previous health; consulted me first in regard to the illness to be described, on May 18, 1895, complaining of ear pains and the other ordinary symptoms of abscess of the middle ear; on the next day the abscess broke and the characteristic purulent discharge in considerable amount followed.

Although considerable relief was obtained from the pains in the ear, there ensued a very persistent and painful supra-orbital neuralgia of the affected side. For two weeks the ear continued to discharge copiously, in fact more copiously than any otitic abscess that had ever come under my observation; but barring the supra-orbital pains there were no symptoms of an unusual character.

On the evening of the 4th of June there was a return in great violence of the deep-seated, intolerable pains in the ear. On the 6th of June there was a discharge of blood and bloody pus from the ear; this I interpreted at the time to signify an invasion of the inner ear; and as there was no swelling or sensitiveness over the mastoid, and as the bloody discharge seemed to give a relief to the deep-seated pain, and as there was no chill or marked elevation of the temperature (it was only 100° F.), I felt myself warranted in believing that the discharge was finding adequate drainage through the natural channels.

The local treatment at this time, as throughout the case, being copious washings with hydrogen peroxide. The supra-orbital pains, however, renewed their maddening torment. They were not intermittent twitchings, but a steady, persistent suffering confined to the region indicated.

Early on the morning of June 12th, I received urgent summons to see him, when, to my surprise, and almost consternation, I found the following condition present: He lay in a

comatose from which it was very difficult to arouse him, the entire left side seemed to be completely paralyzed (it was the right ear that was affected), no motion, no sensation, left pupil stationary and irresponsive to light, tongue protruded with difficulty and deflected to the right side.

I immediately telephoned to Prof. William B. Van Lennep, and he arrived shortly before noon. He advised first a trephining of the mastoid; accordingly he was anæsthetized by Dr. Grisby, and assisted by Drs. I. Crowther, George Webster and myself, Dr. Van Lennep trephined the mastoid cells, and by chisel and gouge worked down to and cleaned out the middle ear. Some congestion was found, but no free pus or broken-down bony tissue discovered except in the cavity of the middle ear.

The man was put back to bed and his condition closely watched. No signs of reaction appeared; unconscious defæcation and urination, a weakening pulse, labored breathing, non-reactive pupils, a failure to exercise on single voluntary muscle, warned us that we had not reached the seat of the difficulty. Towards evening positive indications of pulmonary œdema on both sides appeared; he became bathed in a cold sweat, altogether quite a moribund picture.

About 9.30 p.m. Dr. Van Lennep, accompanied by Dr. Bartlett, again called; a hurried consultation was held; his family were told that there was a remote possibility that his life might be saved by an operation, but frankly told that there was a greater probability that he would die on the table.

When he was finally placed upon the table he was at the point of death.

At my earnest solicitation Dr. Van Lennep concluded to do what he could without anæsthesia; the incision of the morning operation was extended posteriorly, and to knife and trephine the patient was oblivious. The point of the trephine was inserted one and a quarter inches above and one and a quarter inches posterior to the external auditory meatus; after the button of bone was removed, the biters cut their way downwards and forwards, the dura puffed up, congested and showing some pus; after removing about an inch and a half of bone the dura was cut, when out welled pus and broken-down brain material; peroxide was poured into the apparent outlet, and out gushed a mass of soapy foam which must have represented a very con-

siderable amount of débris. A more careful search revealed the outlet of the abscess at the point of the temporo-sphenoidal lobe, and our nearest estimate was that the cavity was at least the size of an ordinary goose-egg.

A rubber drainage tube, two and five-eighths inches long, was introduced into the cavity; and such was our haste to finish that we did not wait to tie the vessels in the scalp, but left on the haemostatic clips, dressing with the ordinary anti-septic toilet.

During the time of operation the patient never moved any part of his body, but those who were watching him said that his pulse improved in tone during the operation.

After being placed in bed, hot packs were placed about him; the first medicine he received was a hypodermic injection of arnica, 3x; later, the pulse becoming more feeble and wavering, I gave 15 M. arom. spir. ammo., which temporarily produced a decided good effect. I spent the entire night at his bedside, the other physicians leaving about midnight. The first sign of reaction was a slight groan; next was an apparent, although unsuccessful, effort to move right leg, but, in the interval, pulmonary oedema had increased to such a degree that it made me highly solicitous. I took my stethoscope, and over the anterior surface of both lungs there was not a spot but where the ominous râle could be heard. About 2 A.M. I injected under the pectoral muscle one one-hundredth of a grain of antimonium crudum, dissolved in water, immediately repeating the injection on the other side; the effect was so prompt and so positive that I was more than delighted. Within ten minutes there was a very decided improvement, and within thirty minutes comparatively easy breathing; and from that time there was noticed a more decided effort to move the right side. About 3 A.M. he moved his right arm, followed soon after by a bending of the right knee; about 4, the watchers were gladdened by seeing him twitch his left shoulder. Shortly before 5 I noticed that he had appeared to swallow the mucus which collected in his throat, and, after several efforts, I succeeded in getting him to swallow some stimulants; about half an hour later, to our joy, he asked for some more whiskey.

His temperature (axillary) had ranged from 97° soon after the operation to 101°, his pulse keeping about 180. By 7, he

was able to swallow easily and speak clearly, but speech was prohibited him. About 4 P.M. on the day following the operation the dressings were removed, the dura partially reunited by catgut, the abscess cavity washed out with hydrogen peroxide, and the parts about packed with iodoform gauze.

During the first forty-eight hours of the reactionary period, after consciousness was restored, the patient developed a most decided tendency to profanity, and all of us were saluted by some profane phrase. This was entirely contrary to his usual habits, as he had never been addicted to the use of profane language, and, later, he expressed a most contrite sorrow over the way he had spoken to us, at the same time saying it was without his consciousness or control.

The daily dressing of the wound, as above described, was kept up for three weeks, in which I was most capably assisted by either Dr. Crowther or Dr. Webster, and often both of them.

On the eighth day after the operation, the patient was again placed under ether, and I stitched with silkworm-gut the edges of the scalp to relieve the task of granulation as much as possible. Eight stitches were introduced, and I obtained complete and entire union of the parts thus reunited, the stitches being removed on the eighth day.

On the twenty-ninth day after the operation I removed the drainage tube, inserting in the depression, rather than cavity, some iodoform gauze. During this entire period of twenty-nine days the drainage tube was never removed, even while dressing the wound; but the abscess cavity was washed out by inserting the nozzle of the syringe into the drainage tube.

The subsequent healing of the wound was rapid and uneventful, the cicatrix being surprisingly slight.

In the care of the wound, no step in the technique of antisepsis was neglected, and, until the wound became entirely a superficial and granulating one, the same care was taken with each dressing as with the primary operation, *i.e.*, sterilized by bichloride saturated towels surrounding wound, instruments boiled before each dressing, and myself and clean assistant careful to touch nothing not surgically clean during the time of dressing wound.

The progress of the patient healthward was gratifyingly rapid,

and his subsequent health has been better than during the same period preceding the operation. He now weighs twenty-five pounds more than he has ever done; is working steadily as an engraver, with full and complete use of all his faculties.

I have deferred reporting the case to this late day, knowing the tendency of many cases of cerebral abscess to return within a few months after operation; but as over fifteen months have now elapsed since the operation, I believe I am warranted in calling it a cured case; and, considering the size and location of the abscess, together with the patient's condition when operated upon, I believe it worthy a place in surgical annals.

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#### A PROTEST.

BY O. EDWARD JANNEY, M.D., BALTIMORE, MD.

To an article in the HAHNEMANNIAN for November by John W. Haywood, M.D., of England, entitled "Prostitution—No License, but Control," I wish to enter an earnest protest. The writer, in brief, takes two positions: first, that "the sexual passions can no more be absolutely suppressed than can the necessity for other evacuations," prohibition being quite as useless as would be that of urinals and water-closets. The second position is that prohibition is impossible, and resort should be had to control and examination.

A careful study of this question for several years has convinced me the best men in our profession are united in the opinion that the sexual appetite may be, and should be, under the control of the will, and that no *necessity* for its indulgence exists, but that the highest degree of mental and physical health may co-exist with perfect continence. Not less than a dozen papers have appeared in our medical journals during the past year which support this view. It would seem to be a most degrading view to take of mankind that it is endowed with powers whose necessary exercise compels the violation of moral and physical laws. Surely the Creator did not make it *necessary* for men to sin.

As to the other point, the experience of Switzerland, of Germany, of France, of the British army in India and at home

proves conclusively that regulation does not regulate nor control; neither does medical examination prevent contagion. As to the plan of restricting women and houses of ill-fame to certain parts of a city, the results of careful trial—as in the instance of the city of Rome—prove that this form of evil cannot be kept to one locality, even under the strictest surveillance.

On the other hand, instances have occurred where prohibition has succeeded, as in Norfolk, Va., and wherever officials are in sympathy with the law. Looked at calmly and in the light of reason and experience, sexual vice does not differ from other forms of vice in essence; it is only more difficult to treat with. The method adopted by the human race in relation to vice is to prohibit it, and it is as appropriate to sexual vice as to other varieties. The difficulty in carrying out the law should not lead to its abandonment. Law has not yet stamped out theft or murder or adultery; shall we then proceed to “control” or “regulate” these evils?

The medical profession should always uphold the highest practical standard in relation to moral and social questions, nor allow themselves to be led to support measures which have been abandoned by the most experienced students of social science the world over.

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#### IMPETIGO CONTAGIOSA.

BY EDWARD M. GRAMM, M.D., PHILADELPHIA, PA.

(Read before the West Jersey Homœopathic Medical Society.)

IMPETIGO CONTAGIOSA is a disease which comes so frequently under the notice of the general practitioner, and can be so very readily cured if proper measures are at once instituted, that the writer considered that its discussion at this time would prove of advantage.

The lesions which characterize the disease when seen in its typical development are always flat pustules that are followed by not very closely adherent crusts, and upon the site of which reddening of the skin and scanty desquamation remain for a short time after the crusts fall off. The pustules pass through

an evanescent vesicular stage, although this may be so indistinctly developed that its existence may be denied by the patient on being questioned concerning it.

The location of the eruption is always upon some portion of the body which is able to be directly reached by contact with the infecting individual, for the disease is markedly contagious as well as auto-inoculable. It is not necessary that the infecting material shall come from a person who has a developed impetigo, and it is this point upon which I would lay particular stress. Many a time a localized epidemic of impetigo among children results from inoculation of one of them by another upon whose fingers or face a mere scratch exists, a scratch in which pus has developed. Others of the children will then contract the typical disease from the one in whom the first characteristic eruption showed itself.

The vesico-pustules which characterize this affection are roundish or ovalish in shape and vary in size; but are usually not well distended with the fluid they contain, some of them manifesting umbilication; the color of the fluid is a pale-yellowish or whitish-yellow. They do not rupture spontaneously, but desiccate and leave behind them the characteristic brownish or honey-colored crusts, which drop off in from four to eight days. They may be so closely aggregated, particularly around the mouth, that the crusts coalesce to form a good-sized patch and cause disfigurement of the face by their presence. It must be borne in mind that they tend to appear wherever the little one habitually touches itself; therefore, the fingers, buttocks, feet, and abdomen, as well as the face, may show the lesions quite numerously. No scarring is ever produced by the disease.

It is not usual for subjective sensations to be annoying, although at times a child will scratch himself while affected by the malady. Ordinarily, the parents will inform the doctor that the child continually picks at the eruption but does not scratch it.

Authorities generally unite in the statement that the disease is of a self-limiting character, and that it usually runs its course in about ten days to two weeks. With this statement, however, my experience is not in accord. I have seen the affection in its fullest development after the lapse of four weeks,

new lesions in process of development and old ones in all stages of progress; not the least sign that the disease was on the wane.

While the oval, partially distended vesico-pustules, with whitish-yellow or pale-yellow contents are the characteristic signs of impetigo contagiosa, yet in many cases there will be minute pustules here and there, as well as distinct bullæ, although they will not be well distended and their contents will be of a cloudy-yellow or slightly milky color. No areola surrounds any of the lesions as a rule, and there are never any indications of a diffuse inflammation of the skin. Often auto-infection from a characteristic pustule will cause a paronychia to develop.

Usually no symptoms indicating a disturbance of the general health are present, although some children will have slight malaise, loss of appetite, etc. All social conditions are exhibited by the patients; but among the poorer classes of the community the affection is most frequently found, possibly because among them the parents have less time to attend to keeping the little ones as clean as they ought to be. Previous ill-health is not necessarily present in the patients suffering from impetigo, according to my observation.

Summarizing, then, impetigo is characterized by roundish or ovalish vesico-pustules; they are located where direct contact with the infecting material occurred; they are not surrounded by an inflammatory areola and no signs of diffuse inflammation of the skin exists; they are not well distended and do not tend to rupture spontaneously; they are followed by brownish- or honey-colored crusts, which are not closely adherent; when the crusts fall off a reddening of the skin remains, upon which a scanty desquamation continues for a short time (no pigmentation); subjective sensations are not marked, a child picks the eruption rather than scratches it; the disease has its origin in a similar one upon another person, or it is developed after any affection in which pus is formed; therefore it can be produced from a mere scratch in which pus has developed, it can follow varicella, scabies, etc.; and it frequently appears after an attack of measles.

So far as differential diagnosis is concerned, the fact of the lesions showing umbilication here and there should lead us to be on our guard against calling an example of the malady

under consideration smallpox, or *vice versa*. Scabies should not be confounded for impetigo, for the former has such marked predilection for the anterior borders of the axillæ, the front of the wrists, the mammae, the penis, the webs of the fingers, and avoids the face (where impetigo is usually best developed), and runs such a definite course in its spread over the body. Ecthyma has a deeper site in its development, has an inflammatory, painful areola, is usually best developed upon the legs, and is most frequent in adults who have become much debilitated through a debauch or other causes. Eczema never has the slight subjective sensations that characterize impetigo, nor is it most marked where ready contact with the surface is possible. Varicella has a more diffuse development of its lesions and they are always of a maculo-vesico-crusty character, of small size; never the vesico-crusty, oval, umbilicated, large lesions of impetigo; then, too, impetigo never shows vesicles within the oral cavity as varicella does.

There is but one method of treatment which will give rapid and permanent results and that is to attack the lesions locally, as well as internally. If the lesions are not very numerous and the pus formation is not very great an ammoniated mercury ointment containing from ten grains to one drachm to the ounce of excipient, will prove a specific. If, however, the lesions show themselves in great numbers and pus development is copious, it will be necessary to apply a powder made up of ten parts of subgallate of bismuth to ninety parts of powdered starch. Before placing any remedial substances in contact with the skin, it is necessary that all crusts be removed. This can be accomplished by thoroughly soaking them with olive oil and then washing with warm water and soap. If one application of oil and the subsequent washing do not remove all of them, the process must be repeated until the desired result is accomplished. Should a patient return to the physician within three days in an unimproved condition the fault is with the carrying out of the instructions, not with the measures recommended. I have yet to see the first case in which the patient was not improved beyond the expectations of those about him where the directions were faithfully and intelligently carried out.

I wish, too, to call attention to a very frequent error in treating this disease—that by the application of fluid antiseptic so-

lutions. Such procedures are worse than useless. The majority of cases of the disease get worse while they are being employed; and the rapid change for the better under the measures recommended, particularly in the hands of some other physician than the one first employed, convinces the patients and their families that time has been lost in the treatment.

So far as internal medication is concerned, those remedies in our *materia medica* which have produced pustules while being proven should be studied first. Those that will occur to you as being in this category are antimonium tartaricum, cicuta, hepar, mercurius *præcipitatus ruber*, sulphur, viola tricolor, and many others.

Where, from the tender age of the patient or other circumstances, no definite indicating symptoms can be elicited, I am in the habit of giving cicuta internally. However, there is but one method of prescribing internally for impetigo, as well as for all other skin maladies, and that is to take into consideration all the conditions surrounding the patient and the various symptoms he may have, and prescribe according to the totality of indicating symptoms. By so doing, none of the remedies named may be determined upon, and yet the disease be rapidly brought under control.

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FATTY EMBOLISM.—Dr. Groube, after having reported the history of a case of fatty embolism following a severe trauma, concludes from his case and the literature, that :

1. Though rare, cerebral fatty embolism may assume a dangerous grade, and should be considered in grave traumatism of the bones and soft parts.
2. The urine should be examined daily for three weeks for the presence of fat.
3. The quantity found in the urinary secretion will be a relative guide, inversely, as to the quantity circulating in the blood, for probably these two stand in inverse order. A slight quantity in the urine with increase of dyspnea indicate a retention of fat in the blood and imminent danger.
5. The dyspnea and lowering of temperature merit special attention.
6. Absolute rest of the injured part is necessary and rational; in complicated fractures only change the dressings when absolutely necessary. Massage is contraindicated. In contusions of the soft parts massage is only allowable later where the blood does not show a tendency to be absorbed.
7. Often contusions give rise to large cavities filled with fluid blood and fat. In these cases opening the cavity hastens healing, and is devoid of danger.
8. If amputation be considered, the danger of fatty embolism should be kept in mind.
9. As to treatment, the kidneys and heart should be stimulated, for the latter digitalis being especially useful.—*La Settimana Medica*, No. 2', 1896 [Osler (*ibid.*) cites Saunders and Hamilton to the effect that they have observed cases where the lung capillaries were blocked with fatty emboli in diabetes. This might explain the so-called "air hunger" (Küsmaul) which precedes some cases of diabetic coma.—Eds.].

## EDITORIAL.

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### INFINITESIMALS IN NATURE.

AMONG the various causes for the failure of homœopathy to gain the full recognition which its practical results merit, the doctrine of infinitesimals has been one of the most, if not the most, powerful one. So constantly is this operative, even among the adherents of the cause, that in the minds of many it constitutes the main part of homœopathy, and in their dense ignorance of the subject, upon it alone is founded their opposition. While we are as a rule disposed to allow such to remain wedded to their idols, and to waste no time or thought in seeking to enlighten them, it seems proper occasionally in a general way to point out that even in this direction the genius of Hahnemann was not so nearly allied to insanity as they would have us believe.

The infinite divisibility of matter always remains a thinkable proposition, the opposite of which is illogical and absurd. The whole always being greater than any of its parts, anything, however infinitely small, is greater than its halves, for example, into which we can imagine it divided. Whether this division can be carried out with our present methods of trituration and dilution, and, more important still, whether this division if carried out can be recognized by the present means at our command, remain open questions. To the ordinary means, chemical, microscopic, spectroscopic, etc., we as physicians in using our remedies are justified in adding the clinical test. This can never be absolutely convincing, since the opportunities for making strictly scientific control experiments are wanting; but every observed fact capable of proof, pointing to effects produced by minute subdivisions of matter, tends to remove from the mind the element of incredulity which is our legacy from a past gross materialistic age, the views of which have been so wonderfully modified by the precise methods of science rendered possible by the inventions of the past couple of decades.

One of the most interesting of such observed facts concerns

the sundew, our own *drosera rotundifolia*, which, as is well known, is an insect-eating plant. In a paper in the *Popular Science News* for November, besides many interesting details of experiments made upon the plant as to its digestive functions, and its power to discriminate between a valuable food substance and a useless or harmful substance, attention was drawn to the wonderfully small quantity of various salts which were capable of causing movement in the gland tentacles with which its leaves are covered. A minute drop containing 1-960 of a grain of carbonate of ammonia placed on the centre of the leaf was sufficient to cause the marginal tentacles to become inflected. A drop containing 1-14,400 of a grain when placed on the gland, and 1-268,000 when absorbed by a gland caused an inflection of the tentacles. Of nitrate of ammonia 1-691,200 part of a grain excited each tentacle to movement, and with the phosphate even more wonderful results were noted. When a leaf was immersed in a solution of such strength that each gland could only absorb the 1-19,760,000 part of a grain, it was enough to excite the tentacles to movement, and even caused the closing of the whole leaf in some instances. Drops of pure water allowed to fall from a considerable height, solutions of gum arabic, sugar, starch, diluted alcohol, olive oil, and an infusion of tea produced no effect.

Surely a beautiful illustration of the truth that of the proper substance only a very minute quantity is necessary to produce an effect.

The application of this truth in homœopathy, where our law enables us in so many cases to select the proper substance—the indicated remedy—is too obvious to call for comment. It serves, however, indirectly to confirm us in our view that the larger the quantity of a substance required to produce a remedial effect, the less is it indicated homœopathically.

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#### MEDICAL SKEPTICISM.

A LATE number of one of our exchanges, in commenting upon the acknowledged falling off in the receipts of physicians generally, while recognizing the influence of the universal stringency in the money market dependent upon the wide-

spread business depression, ascribes it in a measure to the habit of self-prescribing by the laity, so much indulged in at the present time. It very properly lays some of the blame of this latter on the physicians themselves, so many of whom are in the habit of giving to their patients, with their prescriptions, much information on the subject of diseases in general, and of their own cases in particular, very frequently with the sole purpose of impressing them with a sense of their own learning and of their entire fitness to manage the case. It is hardly to be wondered at that the laity has come in this way to regard itself as rather well posted in matters medical, especially as the secular press kindly furnishes it with so much supplementary, almost post-graduate, medical knowledge. We have more than once deprecated the attempt to spread medical knowledge among the people. In matters of hygiene our most unselfish profession may and should seek to instruct the public, but the treatment of disease it should reserve for itself.

It is strange how fearlessly most persons are willing to undertake the treatment of their own ailments and those of others. Persons who would not think of attempting to regulate their own watches do not hesitate to tamper with the much more valuable and delicate machinery of their bodies.

But besides gaining this overweening confidence in their ability to cope with disease, the public has lost much of its former confidence in the physician. So many now "don't believe in doctors," a result naturally following from the publicity given to their occasional inevitable mistakes, and to the kaleidoscopic variations in the medical fads and fancies, with which the dear public are amused and entertained, but most of all from the want of self-confidence in the profession itself. The wide prevalence of medical skepticism is much to blame for the skepticism of the public. Confidence begets confidence. The damage would not be so great were the skeptics content to reserve their views for the circle of those of like minds with themselves, but when a Dr. Schweininger, Bismarck's physician, imparts his skeptical views on the efficacy of medicine to the ubiquitous reporter, it may well be heralded to the world through the press as a "Bomb for Medicine."

Much of the success of the individual physician depends upon the confidence which he has in himself, his remedies, and

their power to cure. Without reducing it to pure suggestion, there is no doubt that the attitude of the patient towards his attendant has much to do with the result of treatment, and especially with the promptness with which that treatment is sought. Nowadays it is usually only after the self-prescriber has become convinced that he has a fool for a patient that he seeks the advice of a physician who *may* know more than himself, but who has persistently expressed doubts as to the efficacy of medicine to modify the course of disease. Whatever skepticism we may have should never be allowed to obtrude itself upon the notice of the public, but should act as a personal incentive to deeper study and more advanced investigation.

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**DRUG SELECTION BY SEQUENCE OF SYMPTOMS : SECAL E IN LOCOMOTOR ATAXY.**

—Ord records the case of a charwoman at 52, who for three months had complained of catching of her feet in walking, nearly throwing her down; also loss of power in her hands, which prevented her sewing. With her eyes shut or in the dark she feels she must fall. Lightning pains dart through her sides and legs. Patella reflexes absent, her walk distinctly ataxic, co-ordination generally affected, pupils react to light but not to accommodation. She complains of muscle voluntaries, constant headache and giddiness. Her husband has been dead ten years; she has several grown-up, healthy children. There is apparently a history of syphilis, twelve years ago. From June 6, 1894, to August 7th, she was treated with several drugs without benefit. The head became worse, with much giddiness, increased on stooping. The corners of her mouth were sore. Dyspnea and palpitation have troubled her.

A careful examination of the clinical history revealed a sequence of disorders that indicated *secale*, and possibly also *stramonium* and *carbo veg.*

*Secale 1x* was given with almost immediate benefit. In two weeks she said the lightning pains were gone, her legs were stronger and she could walk better. In a month there was improvement generally, except in the head symptoms, which caused her much giddiness, dimness of sight and pain. These were worse in a noise, and she fancied people in the street were going to fall on her. *Stramonium 1x* was then ordered. In two weeks she reported that her head was greatly relieved, but her legs were less steady. The two remedies were then given in alternation until October 2d, when she had a severe gastric attack, with much flatulence, nausea and spasms. *Carbo veg. 3x* relieved this at once, and after a week she resumed *secale* and *stramonium*. These drugs were given on and off until January 1, 1895. Patient can now do all her housework and everything, except scrubbing floors, the stooping for which makes her giddy. She can sew almost as well as ever. All signs of incoordination have diminished and, except for occasional slight vertigo, her symptoms are practically gone.

Up to June of this year the patient continued to come occasionally, and several times she has had slight relapses, but *secale* always does her good, *stramonium* relieving the vertigo and *carbo veg.* the stomach attacks. On one occasion the lightning pains and some girdle pains reappeared, and these were relieved at once by occasional doses of *magnesium phosphoricum 3x trit.*, *secale* being given intercurrently.

Two years have now elapsed since the patient was first seen, and there can be no doubt that these remedies suggested by the sequence of symptoms, have for the present arrested the symptoms and rendered the poor woman's life an endurable one.—*Monthly Hom. Review*, August 1, 1893.

## GLEANINGS.

### GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D., AND FRANK H. PRITCHARD, M.D.

**PRIMARY SARCOMA OF THE PLEURA.**—Prof. Cardarelli (Naples) has found sarcoma of the pleura to be chiefly primary, and to appear in individuals who were previously healthy, with accompanying violent symptoms: pains, fever, dyspnoea and rapid aggravation. At the necropsy the pleural cavities are found filled with massive neoplasms, and occasionally the breast, lungs and liver present sarcomatous nodules. The glands are not swollen. [Dr. Ferrand records a case of primary sarcoma of the lung with several enlarged glands in the axilla.—*L'Union Médicale*, 1894.—Eds.] Puncture of the pleura reveals nothing, or, at least, but little fluid, and in some cases a neoplastic node will develop at the place of puncture. A diagnosis between pleuritis and pleural sarcoma is difficult; trauma seems to favor appearance of the latter. The growth may develop in two forms. It may spread in the form of a cuirass of several millimeters thickness in the subpleural connective tissue, without forming tumors in the pleural sac—the pachypleuritis of some writers. The second form is that where the pleural cavity is filled with neoplastic masses. In the first variety there is associated a profuse exudate; in the second, accompanying tumors which compress adjacent parts and lead to a lethal termination. In the former form the intercostal spaces are narrowed, no dislocation of thoracic organs occurs, and if on aspiration one met with a hemorrhagic exudate associated with loss of strength and enlargement of the lymphatics then the diagnosis is certain. In the other variety the diagnosis is easier, for the thorax is irregularly enlarged, particularly those regions under the clavicles and mammae, and the cutaneous veins are dilated and reticulated. Percussion gives a dull sound with considerable resistance and lack of all elasticity. The mediastinal glands are usually enlarged. If one auscultate below the manubrium, tracheo-laryngeal breathing is distinctly audible, which is not the case in pleuritic exudates, or in increase in thickness of the lung at this place. If sarcomatous masses form in the mediastinum, it is rather forced upward than downwards. If the growth be left-sided the heart may be slightly dislocated.

Thoracocentesis will relieve the symptoms for a time and lengthen life. The operation itself is not serious. If the trachea, the recurrent nerve (laryngeal spasm), the superior vena cava or the vena anonyma be compressed by the mass, then aspiration will be of no service.—*Giornale Internationale Delle Scienze Mediche*, Fasc. 1, 1896.

**A CASE OF INTENSE, CONTINUOUS ALBUMINURIA HAVING PERSISTED FOR SEVEN YEARS WITH APPARENT HEALTH.**—Dr. A. de Crésantignes records the interesting case of a man of sixty-seven years, of seemingly robust appearance and constitution, who was apparently in excellent health and without any antecedent history that would point to renal complications, as grippe, syphilis, alcoholism or arterio sclerosis. All his organs were apparently healthy and not the slightest trace of œdema could be detected. Prof. Dieulafoy had examined him and confirmed this. About seven years before he had suffered from an ill-defined disturbance of health, with loss of appetite. His attending physician, in the course of a complete examination, discovered about two gms. of albumin and thirty-two gms. of sugar in his urine at the time, as the twenty-four hours' amount. Since then the patient, after rapidly recovering his health, which has, seemingly, been excellent, has continually presented a persistent albuminuria. He is not emaciated; he is able to bear fatigue as well as normally. The quantity of his urine at first was above the normal—three litres—while now it is about normal—one and a half litres. The quantity of urea is in proportion to the amount of urine and possibly above normal; the uric acid, phosphates and

chlorides were found present in normal quantity. Sugar has not been found constantly; at one time twelve monthly analyses were made without detecting it. Once, after an exclusively vegetable diet, according to Dujardin-Beaumetz, it reached one hundred and forty gms. in twenty-four hours; in general it ranges between fifteen and forty gms. The albumin has never been found absent; the lowest figure which was observed only once in the seven years was one gm., the highest being six and a half gms., which was noticed recently. In general it may be stated that it is tending to increase, for at first it was only two gms. in twenty-four hours, while now it is six and a half gms. It has also been noted that the greater the quantity of urine the more albumin. Digestion, exercise and sleep have apparently no striking influence on the albuminuria. Microscopically, various renal elements were detected at each analysis; hyaline as well as epithelial, fatty and granular casts. The acidity of the urine was five times above the normal.

What is the pathological lesion at the bottom of this case? It cannot be either a parenchymatous nor an interstitial nephritis (?). Nor can it be a so-called "physiological" albuminuria, for here, with a negative history of preceding causes, and in an otherwise normal urine, there should be a slight quantity of albumin with an absence of renal elements. He is inclined to regard it as of dyscrastic origin—arthritism—on account of the patient's obesity, the periodic glycosuria and the augmentation of the excretion of uric acid to three times the normal, for periods of several months at a time. The kidney must be affected on account of the presence of the renal elements, though there is a "disassociation of the morbid acts" (Dieulafoy). In these cases he would give a reserved prognosis. Milk diet was tried, but it was not tolerated, and the patient lost strength; Prof. Dieulafoy is also against this diet in dyscrastic albuminuria. No remedy appeared to influence the amount of albumin except alkalies in large doses.—*La France Médicale*, No. 21, 1896. [Cases of long-standing albuminuria have been reported by various writers worthy of credence. For example, Hawkins of London reports that of a robust man of forty-nine years, who for twenty-five years had presented a great quantity of albumin in his urine. Another is that of a physician who for forty-three years had suffered from albuminuria without offering other symptoms of Bright's disease. Thirty years before he had consulted Bright himself, who had predicted his death within a short time. Prof. Dieulafoy also has observed similar cases and reported them in his work on renal diseases. Drs. Tyson, Caseaux, Lutaud and Dignat have reported analogous cases. Prof. Osler says, "Interstitial nephritis is compatible with the enjoyment of life for many years, and it is now universally recognized that increased tension, thickening of the arterial walls, and polyuria with a small quantity of albumin, neither doom a man to death within a short time nor necessarily interfere with the pursuits of an active life, so long as proper care be taken. I know patients who have had high tension and a little albumin in the urine with hyaline casts for ten, twelve and, in one instance, fifteen years. Serious indications are the development of uremic symptoms, dilatation of the heart, the onset of serous effusions, the development of Cheyne-Stokes breathing, persistent vomiting, and diarrhoea." Prof. Goodno—*Practice of Medicine*, vol. ii p. 393—also takes a hopeful view of these cases, above all, if recognized early.—Eus.]

**MAKED AND LATENT FORMS OF TUBERCULOSIS.**—Prof. E. Maragliano (Genoa) calls our attention to two important though easily overlooked varieties of tuberculosis, the larval and the latent forms. This disease may penetrate into the body, and form a focus of organic infection, giving rise to the characteristic signs and symptoms without distinct physical signs being detectible. The lungs may be affected with disseminated tubercles, and yet no physical sign be appreciable, while fever, emaciation and cachexia are present. The latency may be limited in time or be intermittent. In the former form, after a certain period of time, in an individual in seemingly good health, a violet pulmonary hemorrhage sets in, or the explosion occurs simultaneously with an acute infectious disease, of which influenza is a typical example. After developing, the tuberculosis may progress, remain stationary or again become latent, to remain so forever or to intermit after longer or shorter periods. Instead of a hemorrhage a bronchitis may set in, the patient recover in a short time, and the disease remain latent till the next seizure; this variety is frequently misunderstood both by the physician and patient. Emphysema develops, then tuberculosis, with consequent permanent consumption—phthisis.

Larval tuberculosis manifests itself in two distinct varieties, the dystrophic and the typhoid.

In the dystrophic form there is chiefly a disturbance of nutrition ; the patient loses slowly in health, anaemia sets in, his red corpuscles decrease in number, the hemoglobin diminishes, and a typical chlorosis appears ; his heart action becomes weak, his pulse rapid ; the appetite is lacking, digestion poor, strength faulty, nervous activity decreased ; his mind is depressed ; in short, there is a bodily ruin without apparent cause. In the female the menses decrease and cease. With all this there is fever, but focal signs in the lungs and elsewhere are absent. The tuberculous localizations become appreciable later, most frequently in the respiratory passages, then in respective frequency in the serous membranes, then the peritoneum and the kidneys, while there are cases where no focus can be detected.

The typhoid form pursues a febrile course at first, and then disturbances of innervation are added. At first intermittent, then remittent or subcontinuous, the fever is associated with vacillating symptoms from the digestive organs and nervous system, which oscillate with the height of the febrile process. Loss of strength is noticeable. The temperature may be moderate or high, and it assumes a typhoid character, with swelling of the spleen, here and there an exanthem, and intestinal symptoms. This form may terminate by retrogression of all the symptoms in a few days and restoration to health, and the physician thinks a typhoid fever is present until a second and a third attack follow, with intervals of a year or more, until a focus is found, usually in the lungs. Frequently phthisics will relate that they have had typhoid fever two, three or even four times in the preceding years. The duration of the fever may be transient or long. The "growing fever" of children entering youth should be regarded with suspicion.—*Berliner Klinische Wochenschrift*, No. 19, 1896. [Prof. Goodno (*Practice of Medicine*, vol. i., p. 34) considers these methods of onset in tuberculosis quite exhaustively. Osler (*Practice of Medicine*, p. 218), amongst the six characteristic modes of onset, also considers these dystrophic forms, i.e., with dyspeptic and anæmic symptoms or with haemoptysis in an apparently healthy subject.—Eds.]

## GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D., AND H. L. NORTHRUP, M.D.

**PICRIC ACID IN THE TREATMENT OF SUPERFICIAL BURNS AND SCALDS.**—Power states that the treatment of such injuries has long seemed to be most unsatisfactory, for they are attended with an unnecessary amount of inflammation, while the act of renewing the dressings is unduly painful. He has come to the conclusion that the picric acid treatment is by far the simplest and most satisfactory. The method is well known in France.

The solution of picric acid is made by dissolving a drachm and a half of picric acid in alcohol, which is then diluted with two pints of distilled water. This is a saturated solution of picric acid.

The clothing over the injured part should be gently removed, and the burned or scalded portion should be cleaned as thoroughly as possible with a piece of absorbent cotton soaked in the lotion. Blisters should be pricked, and the serum should be allowed to escape, care being taken not to destroy the epithelial surfaces. Strips of sterilized gauze are then soaked in the solution of picric acid, and are so applied as to cover the whole of the injured surface. A thin layer of absorbent cotton is put over the gauze, and the dressing is kept in place by a light linen bandage. The moist dressing soon dries, and it may be left in place for three or four days. It must then be changed, the gauze being thoroughly moistened with the picric acid solution, for it adheres very closely to the skin. The second dressing is applied in exactly the same manner as the first, and it may be left for a week.

The great advantages of this method of treatment are: First, that the picric acid seems to deaden the sense of pain ; and, secondly, that it limits the tendency

to suppuration, for it coagulates the albuminous exudations, and healing takes place under a scab consisting of epithelial cells hardened by picric acid. A smooth and supple cicatrix remains, which is as much superior to the ordinary scar from a burn as our present surgical scar is superior to that obtained by our predecessors, who allowed their wounds to granulate.

Power has every reason to be satisfied with the results obtained. It is not an ideal method, for it stains the clothes and discolors the hands of the surgeon, but it is a great improvement upon anything else known.—*British Medical Journal.* [Apply the sterilized gauze to the burned surface, and pour the picric acid upon this dry dressing, thus obviating the staining of the hands; alcohol or water, used at once, will remove the yellow color if the skin becomes stained.—Eds.]

**ITROL (SILVER CITRATE) IN THE TREATMENT OF GONORRHOEA.**—Werler contributed to the *Berliner Klinische Wochenschrift* an article on the use of this agent, introduced by Credé, in the treatment of gonorrhœa.

Werler states that in the course of about six weeks, in private and public practice, he has used it in at least fifty cases of acute and chronic gonorrhœa, in acute urethritis in women, gonorrhœal inflammation of the vulvo-vaginal gland and in a few cases of chronic cystitis, with very favorable results. It is used as an injection in the ordinary way, also in irrigations according to Diday's method and by a modification of Janet's procedure, consisting in washing the entire urethra with a lukewarm solution of the silver salt by means of a large syringe. In acute gonorrhœa he prescribes at the outset a very weak solution, 1 to 8000, and gradually increases the strength. The injections may be used four times a day. The solution should be kept in a yellow bottle. It is important that it should be resorted to without loss of time, before the gonococci have penetrated deep into the mucous membrane. Even in very weak solutions, silver citrate is an energetic antiseptic, disinfectant and germicide.

He sums up as follows: Itrol has an intense gonococcus-destroying action; it is readily borne by the urethral mucous membrane, and causes no noteworthy irritation or increase of the inflammation; its action is deep reaching, but without injury to the mucous membrane; it therefore, meets all of the requirements of an efficient remedy for gonorrhœa.

**ANESTHESIA.**—*The Medical and Surgical Reporter* gives the following instances in which chloroform is the preferable anesthetic: 1. Chronic endarteritis occurring in those advanced in years; 2. Chronic inflammatory affections of the respiratory tract or advanced pulmonary disease. Of course acute catarrhal affections of the respiratory tract are equally forbidding to the use of ether, but a patient suffering from such an acute inflammation should, lest delay were hazardous, be cured of his catarrhal condition before being subjected to any operative interference requiring a general anesthetic; 3. Renal disease, acute or chronic; 4. When there is a history of ether having been taken badly at some former operation; 5. Chronic alcoholism; 6. Those cases in which the galvano-cautery is to be used in the neighborhood of the mouth or ear passages; 7. Cerebral tumors or abscess; 8. In old age; 9. In puerperal eclampsia where an immediate effect is required; 10. Night operations with artificial light; 11. During labor; 12. In military and naval practice, on the field of battle, its use seems to be at times justified, although strongly contraindicated.

The following conditions are looked upon as peculiarly unsuited for its administration, if not, indeed, prohibited: 1. Surgical shock; 2. Epilepsy; 3. Spina bifida and hydrocephalus (Morton); 4. When there is a tendency to syncope; 5. Fatty heart and chronic valvular disease; 6. Acute alcoholism, delirium tremens (Sansom); 7. Fatty liver; 8. It is unsafe to give chloroform to a patient already under the influence of chloral, whether in obstetrical practice or otherwise.

**INDICATIONS FOR THE REMOVAL OF SURGICAL DRESSINGS.**—1. Removal of stitches; 2. Removal of drainage tubes; 3. Saturation of dressings by an abundance of discharge; 4. Soiling of dressings by faeces, urine or vomited matter; 5. The disturbance of dressing by a restless patient; 6. Pain if it is due to pressure, and especially if of a pulsating character; 7. The occurrence of secondary hemorrhage; 8. Fever, if it points to some trouble in the wound.—*Medical Record.*

**FISTULA IN ANO.**—Gant gives the following twelve cautions that should be observed in operating for fistula in ano: 1. Always operate under rigid aseptic conditions; 2. Be certain that all sinuses and all diverticula have been divided; 3.

See that the director is not forced out of the main tract into the neighboring tissues; 4. Divide the sphincter at a right angle and not obliquely; 5. Ligature or twist all spurting vessels; 6. Guard against injuring the peritoneum when the sinus is high up; 7. Guard against cutting the vagina, prostate or urethra when the sinus is in the anterior wall of the rectum; 8. Do not operate on patients suffering from acute phthisis or Bright's disease; 9. Give patients the benefit of the sun as much as possible; 10. Do not pack the dressings tightly after the first twenty-four hours, but lay the gauze loosely in the bottom of the tract; 11. Warn your patient of the possibility of incontinence following the operation; 12. Be guarded in your prognosis.—*Langedale Lancet*.

## GYNAECOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D.

**THE TREATMENT OF PELVIC SUPPURATION.**—Walthard.—Simple incision and drainage is indicated in the treatment of acute pelvic abscess of the cellular tissue. The site of the incision is indicated by the pointing of the abscess. Suppurating hæmatoceles are to be treated in the same manner. The treatment of a circumscribed pelvic abscess originating in the appendages by simple incision and drainage is receiving much support in consequence of the improved methods of vaginal disinfection and drainage. It can be employed with certainty in these cases when the pus sack is one sided, if it has thin walls, if it fluctuates, if it is low down at one side of the uterus or if by pressure on the abdomen it can be easily brought in contact with the vaginal wall. Simple incision is best indicated for acute suppuration of the ovary and tube, with severe general symptoms, and when the virulence of the pus contraindicates either laparotomy or hysterectomy. Failure of the vaginal incision does not exclude hysterectomy if suppuration recurs or if a suppurating fistula remains.

Laparotomy and vaginal hysterectomy for pelvic suppuration are not rivals; each has its indications and advantages.

The indications for laparotomy are determined by unilateral disease and doubt of bilateral disease in a young woman. This rule loses part of its value in suppurative diseases. If one side is suppurating, it is rare that the other side is not involved in the future. All efforts at diagnosis must be to determine whether the disease is unilateral or bilateral.

If there is any doubt in the diagnosis, or if there is a possibility of an ovarian cyst, a dermoid of the ovary or an extra-uterine pregnancy, laparotomy is the operation of choice.

If both sides are diseased, and the indications for both operations come up for consideration the position of the focus of suppuration, whether it lies close to the uterus or to the vaginal vaults is important in making a decision. If the site of suppuration is close to the fundus of the uterus, i.e., more abdominal than pelvic, and it is not surrounded with thickened and indurated tissue, laparotomy is to be preferred.

Vaginal hysterectomy should be practiced for opening and draining the collection of pus in the appendages which are solidified with the surrounding tissue or are closely adherent, and which are separated from the abdominal cavity by solid organic tissue or true fibrous tissue. In these cases laparotomy and any attempt at enucleation are dangerous. Vaginal hysterectomy is better suited than any other method for the cure of chronic suppuration of the pelvic connective tissue which has been left to open spontaneously, in which there is very often close adhesions with the neighboring organs. In these operations the object is to provide for a free escape of pus. If, under these circumstances, extirpation of the pus sack is undertaken all the advantages of a simple and favorable operation are sacrificed, and the most important factors in the treatment of pelvic suppuration by vaginal hysterectomy are misunderstood. The immediate successful results of laparotomy can no longer be used as an argument for that operation, as the success of the vaginal operation has become very apparent in the last few years.

The advantage of the vaginal operation is that it can be employed for those lesions in which laparotomy is unsuccessful and dangerous.—*Centralblatt für Gynäkologie*, No. 38, 1896.

## MONTHLY RETROSPECT OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

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CONDUCTED BY

CLARENCE BARTLETT, M.D.,  
FRANK H. PRITCHARD, M.D., AND F. MORTIMER LAWRENCE, M.D.

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**SARCODES AND HOMŒOPATHY.**—Clark, in a paper presented to the International Homœopathic Congress, referred to the use in ancient medicine of animal preparations, to which he gave the name "sarcode," and he ascribed the modern revival of sarcotherapy mainly to the doctrine of "internal secretions" advocated (though not originated) by the late Dr. Brown-Séquard. After referring to the uses which have been made of *orchitin*, or testicular extract, Dr. Clarke passed on to the consideration of *thyroidin* as being the sarcode most in use and as typical of all the rest. He explained how he came to use it, first of all, in its dynamized form, and illustrated its action in cases of hysteria and neurasthenia, emaciation, diabetes, heart disease and psoriasis. After brief references to other sarcodes—*pituitary extract*, *adrenalin* and *cerebrin*—Dr. Clarke referred to the questions raised by the experiences. He maintained that in whatever dose the sarcode cured the effect was specific and not in the nature of a food. He compared the action of *thyroidin* in myxoedema with the use of iron in anaemia, and maintained that the success of the treatment by *thyroidin* in cases of defective thyroid action was no proof that it acted as a food and not as a medicine. Iron would benefit some cases of anaemia when given in a crude form, but it would also cure in the potencies. He maintained that a large number of its effects were obviously specific and homœopathic.

Dr. Clarke went on as follows:

Another question of great importance is brought forward by experience with *thyroidin* and other sarcodes, viz., their applicability in diametrically opposite conditions. Of course this is not confined to these substances, but it is perhaps more signally exemplified in them than in more usual remedies. I have never been able to find any practical help in the theory of the opposite action of remedies in large and small doses—"large" and "small" in these matters are entirely relative terms. There are some patients who cannot take some medicines either in the crude form or in the highest attenuation. Dr. Dyce Brown has recorded a case in which the 2<sup>4</sup>th of *arnica* would cause erysipelas. On the other hand, many drugs are capable of causing diametrically opposite conditions—as obesity and emaciation, plethora and anaemia, diarrhoea and constipation—and when this is the case, either of these conditions may be taken as an indication for the use of the drug. The second case in which I used *thyroidin* was that of an emaciated boy of five years who did not look more than two, and was perfectly unable to walk, having lived in an underground cellar all his life. I concluded that as *thyroidin* produced such rapid emaciation in myxoedema, it ought to be useful when that condition was present from other causes. I put the boy on *thyroidin* 3x, and he began to put on weight with much greater rapidity than he had before, and this continued until he was taken with diphtheria, through which he passed without trouble by the help of *merc. cyan.* The last point with which I shall deal is the value of symptoms observed in the sick, either positive or negative—that is, either produced or cured. I have not the slightest hesitation in saying that my experi-

ence goes to show that for practical purposes a symptom cured is as valuable as a symptom caused. No drug can either cause or cure any symptom which is not within its range of action. This confession of faith also involves the admission of observations on the sick. Persons who have natural susceptibilities to the action of certain drugs are the best subjects for displaying the pathogenetic effect of those drugs. Persons who have diseases which bring them into homeopathic relation, have an accidental idiosyncrasy to the action of those drugs which may either cure without aggravating, and so confirm the homeopathicity, or may aggravate and cause new symptoms, I maintain that the aggravated and the new symptoms are just as valuable for prescribing purposes as if they had been caused by the drug when given to healthy persons. They are, in short, "positive effects."—*Hom. World*, Sept. 1, 1896.

**A PROVING OF NUX MOSCHATA.**—Stonham, of London, Eng., records the case of a young man, of dark hair and complexion, who ate two nutmegs one Friday morning. No immediate effect. In the afternoon he noticed, when he passed his urine, that it had an aromatic odor. He felt exhilarated and able to do more than usual. He "beat his record" in getting from the station on his way home, and felt mentally exalted also, as if he could argue and hold his own on any subject. At dinner he was extremely thirsty, the mouth feeling very parched; he felt he could not drink enough to quench his thirst. After dinner he joined, as he had intended, in a small musicale, but did not feel equal to it; his head felt strange and as if in a dream. He seemed to be two persons, and his real conscious self seemed to be watching his other self playing. He could not play well, and struck several false notes, and was at last obliged to give it up. He seemed lost, and when spoken to would come to himself with a start. His hearing for distant sounds was much more acute than usual—he could hear people talking in a low voice outside the room, which he would have been quite unable to do ordinarily. On retiring to bed, sleep was disturbed by a tendency to nightmare. The next day he felt languid and tired, and unfit to work, but the other symptoms had passed off. The skin was dry and almost jaundiced, as people often appear after a bilious attack. Tongue dry and furred at back. Bowels confined. He was not seen till the Saturday afternoon, when the symptoms had mostly passed away, so that only those have been given which he was able to relate.—*Monthly Hom. Review*, August 1, 1896.

**SANGUINARIA IN OVARIAN NEURALGIA.**—As an instance of drug selection, according to sequence of symptoms, Ord relates the case of a young woman, æt. 22, who for twelve months had suffered from pain in the right side. She had been attending a hospital for four months, was an in-patient for two weeks, and was blistered on side and back, without benefit. Patient a florid, bright woman, unmarried. The right ovary very tender to external pressure. She described the pain as constant aching, very distressing, and incapacitating her from active work. It was much worse at the periods and after exertion. There was also a pain over the right hip, worse in wet weather; no tenderness or swelling. The periods recurred every two weeks, very profuse and bright, with such severe pain that she had to lie up every time. Bowels constipated. For six weeks she was given in turn belladonna, nux vomica and hépar. Of these, the last relieved the hip-pain, but she was no better otherwise.

**Clinical History of Case**—She enjoyed good health, and menstruation was normal until fourteen months ago, when she suffered from indigestion and constipation, followed by flushing and redness of face, with constant headaches. The pain in the side then appeared and the periods became too frequent and profuse. This sequence indicated *sanguinaria*, which, agreeing well with the symptoms, was ordered in the 1st. dec. dil. gtt. v. t. d. e.

In a fortnight she reported great improvement. Pain almost gone. The period had just passed, less profuse, very little pain, and she had not to lie up for it. In another fortnight, *sanguinaria* being continued, she returned considering herself cured, and feeling better than for many months. Patient was advised to continue the remedy after the next period, and has not returned.—*Monthly Hom. Review*, August 1, 1896.

**THE THERAPEUTICS OF MENORRHAGIA.**—In the functional variety the following drugs, according to the *Homeopathic Guide* (September, 1896), are most frequently indicated:

*Crocus* is one of the best remedies and most frequently called for. The menstrual discharge is profuse, lasts too long, recurs too frequently; blood black, stringy, sticky, clotted.

*China* has much the same character of discharge, but is administered to the best advantage during the intra-menstrual periods to overcome their weakening effect, while *crocus* should be given at the time.

*Sabina* is indicated by a more active condition than that calling for *crocus* or *china*. There are some evidences of congestion or threatening inflammation in the pelvis. The uterus and its appendages are sore, sensitive to touch, the blood is red, arterial.

*Belladonna* is called for in aggravated *sabina* condition. The local symptoms are more pronounced; great soreness and sensitiveness over womb and ovaries; bearing-down sensations as though everything would fall out; blood bright red; patient very irritable, nervous.

Patients suffering from menorrhagia should observe common-sense rules in regard to their general treatment. Rest in bed is important at the time in all cases; relief from household cares that wear and tear; generous diet; in fact, anything and everything that adds to the woman's happiness and comfort. Improvement of the general health is of the first importance.

**GRAPHITES IN CHRONIC CILIARY BLEPHARITIS.**—In those cases in which this remedy is useful the edges of the lid will usually be found slightly swollen and of a pale red color; the inflammation may be confined to the canthi (*blepharitis angularis*), especially to the outer, which have a great tendency to crack and bleed easily upon any attempt to open the lids; the margins may be ulcerated; dry scurfs are usually present on the cilia.—*Hom. Eye, Ear and Throat Journal*, November, 1895.

**RHUS TOX. AND PHYTOLACCA IN PANOPHTHALMITIS.**—The symptoms are more intense, pain more severe and inflammation more active under *rhus* than under *phytolacca*. The lids are also edematosly swollen and lachrymation profuse in *rhus*, while they are hard, bluish-red and swollen in *phytolacca*.—*Hom. Eye, Ear and Throat Journal*, November, 1895.

**Lycopodium in Hemeralopia.**—No other drug in our *materia medica* has cured such a large number of these cases as *lycopodium*. There seems to be no marked indication for its use, with the exception of the night blindness coming on in the early evening, though in some instances it was found that the patient could see better at a distance than near at hand, yet in other cases this indication was wanting, so it cannot be considered important. If black spots floating before the eyes accompany the night blindness this drug is particularly called for.—*Hom. Eye, Ear and Throat Journal*, August, 1895.

**Phosphorus in Retinitis.**—In both hyperæmia and inflammation of the retina favorable results have been obtained from this remedy. In one case it relieved very quickly a congestion of the retina in which the balls were sore on motion, pains extending from the eyes to the top of the head.—*Hom. Eye, Ear and Throat Journal*, August, 1896.

**The Therapeutic Uses of Rhus Aromatica.**—As all know, *rhus aromatica* is one of those valuable remedies rescued and saved from oblivion by Hale's *New Remedies*. The remedy was originally brought to notice by Dr. F. McClanahan, who stated that he obtained his first knowledge of its virtues from his grandfather, Dr. John Gray, who had used the drug for over thirty years with the utmost benefit to his patients. *Rhus aromatica* in material doses is "a sovereign remedy" for diabetes. The dose runs from ten drops to a teaspoonful of the mother tincture. Another use of the remedy is in the cure of that annoying complaint, involuntary dribbling of the urine. It is also a great remedy for enuresis; indeed, a few years ago Dr. Worthington, of Versailles, Ky., said it was practically a specific for this troublesome complaint. He does not look for symptoms, but when he has a case of bed-wetting to treat he gives *rhus aromatica* in ten-drop doses. It has, like everything else, been also recommended for other complaints, and may be useful in them, but in diabetes, dribbling of urine, or incontinence of urine, and enuresis, it stands forth as a strongly marked remedy.—*Hom. Recorder*, May 15, 1896.

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